



Medical Assistance Administration



DENTAL PROGRAM

Billing Instructions
(WAC 388-535)

July 2000

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About this publication

This publication supersedes all previous MAA Dental Billing Instructions and repeals the following Numbered Memoranda:

**99-17 MAA, 99-47 MAA, 99-56 MAA, 99-59 MAA,
99-66 MAA, 00-44 MAA, 00-51 MAA**

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**Received too many billing instructions?
Too few?
Address Incorrect?**

Please detach, fill out and return the card located inside the back cover of this billing instruction. The information you provide will be used to update our records and provider information.

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Table of Contents

Important Contacts	Section A
Definitions	Section B
Dental Program	Section C
What is the purpose of the Dental Program?	
Becoming a DSHS dental provider	
Client Eligibility	Section D
Who is eligible?	
Clients eligible for limited services	
Managed care clients	
Clients eligible for enhanced services	
Who is not eligible?	
Coverage	Section E
What is covered?	
What is not covered?	
Prior Authorization	Section F
When do I need to get prior authorization?	
What services require prior authorization?	
How do I get written prior authorization?	
Where should requests for prior authorization be sent?	
Billing	Section G
What is the time limit for billing?	
What fee should I bill MAA?	
How do I bill for clients eligible for both Medicare and Medicaid?	
Third-Party Liability	
What records does MAA require that I keep in the client's file?	
Notifying Clients of Their Rights (advance directives)	
Completing the American Dental Association (ADA) Claim Form	Section H
Completed samples of ADA claim form	
Blank ADA form	
Teeth Charts	Section I
Primary Teeth Chart – Names and Letters	
Permanent Teeth Chart – Names and Numbers	

Table of Contents (cont.)

Dental Fee Schedule Section J

Guide to using the fee schedule
 Site of Service (SOS) payment differential
 Fee Schedule

Diagnostic	Periodontics
Preventive	Prosthodontics, Removable
Restorative	Prosthodontics, Fixed Repairs
Endodontic	Oral Surgery – Dentists

OrthodonticsSection K

What is covered?
 Who is eligible?
 Is written prior authorization required?
 What are MAA's Criteria for Orthodontic Services?
 Orthodontic treatment
 What about orthodontic treatment beyond the client's eligibility period?
 When do I need to fill out the Orthodontic Information Sheet?
 Orthodontic Examination Fee
 Orthodontic Examination Review Results from MAA
 Submitting Additional Information
 Study Models
 When do I bill?
 Orthodontic Information Sheet
 Fee Schedule
 Evaluation and Management (E&M) procedure codes - for use only by orthodontists
 participating in cleft palate/craniofacial anomaly case management teams

Miscellaneous..... Section L

Unclassified Treatment
 Anesthesia
 Professional Visits
 Drugs
 Miscellaneous Services

Oral Surgery - Surgeons.....Section M

Hospital
 Assistance Surgeon
 Oral Surgery
 Fee Schedule

Integumentary System	Respiratory System
Musculoskeletal System	Digestive System

Table of Contents (cont.)

Emergency Medical/Dental State-Only Programs.....Section N

Who does this program apply to?

Billing Procedures

Is prior authorization required?

How do I obtain written prior authorization?

Where should I send my claim?

Fee Schedule

Diagnostic	Adjunctive General Services
Oral Surgery – Dentists	Integumentary System
Restorative	Respiratory System
Prosthodontics, Removable	Digestive System

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Important Contacts

How do I become a DSHS provider?

Call the Provider Enrollment Unit according to the first letter of your business name:

A-H	(360) 664-0300
I-O	(360) 753-4712
P-Z	(360) 753-4711

Where do I send my dental bill?

Division of Program Support
PO Box 9253
Olympia WA 98507-9253

Who do I call to request free in-office provider training?

Dee Dee Howden	(360) 664-0610
Debbie Wingfield	(360) 586-7040
Rita Honc	(360) 664-0297

Where do I write to get prior authorization?

Quality Utilization Section
PO Box 45506
Olympia WA 98504-5506

Where do I call if I have questions on...

Policy, payments, denials, general questions regarding claims processing, or Healthy Options?

Provider Relations Unit
1-800-562-6188

Private insurance or third-party liability, other than Healthy Options?

Coordination of Benefits Section
1-800-562-6136

Electronic Billing?

(360) 753-0318

or write to:

Electronic Billing
PO Box 45564
Olympia, WA 98504-5564

Where do I write to request copies of billing instructions?

Check out our web site
<http://maa.dshs.wa.gov>

or write to:
Provider Relations Unit
PO Box 45562
Olympia, WA 98504-5562

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Definitions

This section contains definitions of words and phrases that the Department of Social and Health Services (DSHS) uses in these billing instructions. Further dental definitions used by DSHS may be found in the Current Dental Terminology (CDT) and the Current Procedural Terminology (CPT™). **Where there is a discrepancy between the CDT or CPT and this section, this section prevails.**

Adult – For purposes of the dental program, adult means a client 19 years of age or older. (WAC 388-535-1050)

American Dental Association (ADA) – The ADA is a national organization for dental professionals/dental societies.

Anterior – Teeth in the front of the mouth. In relation to crowns, only these permanent teeth are considered anterior for laboratory processed crowns:

Lower Anterior - 22, 23, 24, 25, 26, 27;
Upper Anterior - 6, 7, 8, 9, 10, 11.

Authorization - An official approval for action taken for or on behalf of an eligible Medical Assistance client. This approval is only valid if the client is eligible on the date of service.

Authorization Number - A nine-digit number, assigned by the Medical Assistance Administration (MAA), that identifies individual requests for services or equipment. The same authorization number is used throughout the history of the request, whether it is approved, pending, or denied.

Bicuspid – Teeth 4, 5, 12, 13, 20, 21, 28, and 29.

By Report (BR) – A method of payment for a covered service, supply or equipment which:

- Has no maximum allowable established by MAA;
- Is a variation on a standard practice; or
- Is rarely provided.
(WAC 388-535-1050)

Caries – Tooth decay.

Categorically Needy Program (CNP) - A program providing maximum benefits to persons who qualify for Medical Assistance.

Child – For purposes of the dental program, child means a client 18 years of age or younger. (WAC 388-535-1050)

Client - An applicant for, or recipient of, DSHS medical care programs.

Code of Federal Regulations (CFR) - A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Community Services Office (CSO) - Field offices of the Department of Social and Health Services located in communities throughout the state which administer various services of the department at the community level.

Core Provider Agreement - A basic contract that MAA holds with medical providers serving MAA clients. The provider agreement outlines and defines terms of participation in the Medicaid program.

Craniofacial Team – A Department of Health and MAA-recognized cleft palate/maxillofacial team that is responsible for management (**review, evaluation and approval**) of patients with cleft palate and/or craniofacial anomalies, to provide integrated case management, promote parent-professional partnership, making appropriate referrals to implement and coordinated treatment plans. (WAC 388-535-1050)

It is recommended that the minimum core team be composed of a:

- ✓ oral maxillofacial surgeon;
- ✓ dentist;
- ✓ physician, and
- ✓ speech/language pathologist.

The team may also include other specialists from a group of selected professionals:

- ✓ geneticist or genetic counselor,
- ✓ nurse,
- ✓ orthodontist,
- ✓ otolaryngologist,
- ✓ pediatrician,
- ✓ plastic surgeon(s),
- ✓ prosthodontist,
- ✓ social worker,
- ✓ psychologist,
- ✓ additional speech pathologist,
- ✓ nutritionist, and
- ✓ feeding therapist.

Current Dental Terminology, Second Edition (CDT-2) – A systematic listing of descriptive terms and identifying codes for reporting dental services and procedures performed by dental practitioners. The Council on Dental Benefit Programs of the American Dental Association (ADA) publishes CDT-2. CDT is used for the majority of the procedure codes used by MAA in this Billing Instructions.

Current Procedural Terminology (CPT™) – A description of medical procedures available from the American Medical Association of Chicago, Illinois.

Dentally Necessary – Diagnostic, preventive, or corrective services that are accepted dental procedures appropriate for the age and development of the client to prevent the incidence or worsening of conditions that endanger teeth or periodontium (tissues around the teeth), or cause significant malfunction, or impede reasonable development or homeostasis (health) in the stomatognathic (mouth and jaw) system:

- It may include simple observation with no treatment, if appropriate; and
- Includes use of less costly, equally effective services.
(WAC 388-535-1050)

Dental Practitioner - A person licensed by the state Department of Health as a dentist, dental hygienist, or denturist (chapters 18.32 RCW 19.29 RCW).

Department - The state Department of Social and Health Services.

Division of Developmental Disabilities

(DDD) - The division within DSHS responsible for administering and overseeing services and programs for clients with developmental disabilities.

Division of Program Support (DPS) - The division within the Medical Assistance Administration that processes claims for payment under the Title XIX (federal) program and state-funded programs.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) - Also known as the "healthy kids" program, means a program providing early and periodic screening, diagnosis and treatment to persons under 21 years of age who are eligible for Medicaid or the children's health program. (WAC 388-500-0005)

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Managed Care – A comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary services. Managed care involves having clients enrolled:

- With or assigned to a primary care provider;
- With or assigned to a plan; or
- With an independent provider, who is responsible for arranging or delivering all contracted medical care.

Maximum Allowable - The maximum dollar amount MAA will reimburse a provider for specific services, supplies, or equipment.

Medicaid - The federal aid Title XIX program under which medical care is provided to:

- Categorically needy program [CNP] as defined in WAC 388-503-0310 and 388-503-1105; or
- Medically needy program [MNP] as defined in WAC 388-503-0320.

Medical Assistance Administration

(MAA) - The administration within the Department of Social and Health Services authorized to administer the acute care portion of the Title XIX Medicaid and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- a) "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- b) "Part B" is the supplementary medical insurance benefits (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other services and supplies not covered under Medicare Part A. (WAC 388-500-0005)

Molars – Permanent teeth 1, 2, 3, 14, 15, 16, 17, 18, 19, 30, 31, and 32; and primary teeth A, B, I, J, K, L, S, and T.

Oral Evaluation – A comprehensive oral health and development history; an assessment of physical and oral health development and nutritional status; and health education, including anticipatory guidance. (WAC 388-535-1050)

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each Medicaid client and consists of:

- a) First and middle initials (or a dash (-) must be entered if the middle initial is not indicated);
- b) Six-digit birthdate, consisting of *numerals only* (MMDDYY);
- c) First five letters of the last name (and spaces if the name is fewer than five letters); and
- d) Alpha or numeric character (tiebreaker).

Posterior Teeth – Teeth and tissue towards the back of the mouth. Specifically, only these permanent teeth: 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, and 32.

Prophylaxis – Intervention which includes the scaling and polishing of teeth to remove coronal plaque, calculus, and stains.

Provider or Provider of Service - An institution, agency, or person:

- Who has a signed agreement with the department to furnish medical [dental] care , goods and/or services to clients; and
- Is eligible to receive payment from the department. (WAC 388-500-0005)

Reline – To resurface the tissue side of a denture with new base material in order to achieve a more accurate fit.

Remittance and Status Report (RA) - A report produced by the claims processing system in the Division of Program Support, Medical Assistance Administration, that provides detailed information concerning submitted claims and other financial transactions.

Revised Code of Washington (RCW) - Washington State laws.

Root Planing – A procedure designed to remove microbial flora, bacterial toxins, calculus, and diseased cementum or dentin from the teeth's root surfaces and pockets.

Scaling – The removal of calculus material from the exposed tooth surfaces and that part of the teeth covered by the marginal gingiva.

Sealant – A material applied to teeth to prevent dental caries.

Spend-down – The amount of excess income MAA has determined that a client has available to meet his or her medical expenses. The client becomes eligible for Medicaid coverage only after he or she meets the spend-down requirements.

State Unique Procedure Code(s) – MAA procedure code(s) used for a specific service(s) where there is not an ADA-CDT or CPT procedure code available or appropriate.

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a medical program client. (WAC 388-500-0005)

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.

Usual and Customary – The fee that the provider usually charges non-Medicaid customers for the same service or item. This is the maximum amount that the provider may bill MAA. (WAC 388-535-1050)

Washington Administrative Code (WAC)
Codified rules of the State of Washington.

Wisdom Teeth – Teeth 1, 16, 17, and 32.

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Dental Program

What is the purpose of the Dental Program?

The purpose of the Dental Program is to provide high quality, covered dental and dental-related services, equipment and supplies to clients who are eligible.

Becoming a DSHS dental provider (WAC 388-535-1150)

The following providers are eligible for enrollment to provide and be paid for dental-related services to eligible clients:

- Persons currently licensed by the state of Washington to:
 - ✓ Practice dentistry or specialties of dentistry (e.g., orthodontics);
 - ✓ Practice as a dental hygienist;
 - ✓ Provide denture services;
 - ✓ Practice medicine and osteopathy for oral surgery procedures or fluoride varnish under EPSDT/Healthy Kids;
 - ✓ Practice anesthesiology; or
 - ✓ Provide conscious sedation when providing that service in dental offices for dental treatments and when certified by the Department of Health.
- Facilities which are:
 - ✓ Hospitals currently licensed by the Department of Health;
 - ✓ Federally-qualified health centers;
 - ✓ Medicare-certified ambulatory surgical centers;
 - ✓ Medicare-certified rural health clinics; or
 - ✓ Community health centers.
- Participating local health jurisdictions; and
- Border area or out-of-state providers of dental-related services qualified in their states to provide these services.

Note: Licensed providers participating in the MAA dental program may be paid only for those covered services that are within their scope of practice.

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Client Eligibility

Who is eligible? (WAC 388-535-1060)

Clients presenting Medical Assistance IDentification (MAID) cards with the following identifiers are eligible for dental services listed in the dental fee schedule:

- **Children's Health**
- **CNP** (Categorically Needy Program)
- **CNP-CHIP** (CNP-Children's Health Insurance Program)
- **CNP-QMB** (CNP-Qualified Medicare Beneficiary)
- **LCP-MNP** (Limited Casualty Program /Medically Needy Program)
- **MNP-QMB** (Medically Needy Program – QMB)

Clients eligible for limited services:

Clients with the following identifiers on their MAID cards are limited to prosthodontics and the services under the Emergency Medical/Dental State-Only program. (See Emergency Medical/Dental State-Only Programs section.)

- **GAU – No out of state care** (General Assistance – Unemployable)
- **W – No out of state care** (Alcoholism & Drug Addiction Treatment and Support Act)

Clients with the following identifier on their MAID cards are eligible only for emergency services in a hospital setting:

- **Emergency Hospital and Ambulance Only** (Medically Indigent Program)

These emergency services **do not** require prior authorization. No other places of service are covered for clients with the Medically Indigent Program identifier.

Managed care clients

Clients who are enrolled in a Healthy Options managed care plan should have a Health Maintenance Organization (HMO) identifier in the HMO column on their MAID card. These clients are eligible for MAA-covered dental services that are not covered by their plan through MAA's fee-for-service program.

Clients eligible for enhanced services

Developmentally disabled (DD) clients may be entitled to more frequent services for the following treatments:

- Fluoride application
- Root planing
- Prophylaxis (scaling and coronal polishing)

DD clients will have an “X” in the DD client column of their MAID card. Individuals lacking the DD information on their MAID card are not eligible for the additional services. If you believe that a patient may qualify for these services, refer the individual or the patient’s guardian to the nearest Developmental Disabilities Office (see list below).

Division of Developmental Disabilities Field Offices

Region 1

West 1611 Indiana
MS: B23-28
Spokane, WA 99205
(509) 456-2893
(509) 456-4256 FAX
1-800-462-0624

Region 2

1002 N. 16th Avenue
MS: B39-7
Yakima, WA 98909-2500
(509) 575-2330
(509) 575-2326 FAX
1-800-822-7840

Region 3

840 N. Broadway
Building A, Suite 100
MS: N31-11
Everett, WA 98201-1296
(425) 339-4833
(425) 339-4856 FAX
1-800-788-2053

Region 4

1700 East Cherry Street, Suite 200
MS: N46-6
Seattle, WA 98122
(206) 568-5700
(206) 720-3038 FAX
1-800-314-3296

Region 5

1305 Tacoma Avenue S., Suite 300
MS: N27-6
Tacoma, WA 98402
(253) 593-2812
(253) 597-4368 FAX
1-800-248-0949

Region 6

Airustrial Park, Bldg. 6
MS: 45315
PO Box 45315
Olympia, WA 98504-5315
(360) 753-4673
(360) 586-6502 FAX
1-800-339-8227

*If you have any problems contacting these field offices, call Connie Clark,
DDD state office, at (360) 902-8475*

Who is not eligible?

Clients with the following identifiers on their Medical Assistance IDentification (MAID) cards are not eligible for dental services listed in this dental fee schedule:

- **Family Planning Only**
- **QMB – Medicare Only** (Receive funding for Medicare premium only)

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Coverage

What is covered? (WAC 388-535-1080)

1. MAA pays only for covered dental and dental-related services, equipment, and supplies listed in this section when they are:

- Dentally necessary;
- Within the scope of the eligible client's dental care program;
- Within accepted dental or medical practice standards and are:
 - ✓ Consistent with a diagnosis of dental disease or condition; and
 - ✓ Reasonable in amount and duration of care, treatment, or service.
- Billed appropriately (e.g., on the correct claim form, using the correct procedure code(s), and within MAA's guidelines and timeframe).

All items and services are subject to the specific limitations listed in the fee schedule.

2. The following dental-related services **are covered**:

- Oral health evaluations/assessments, including oral health screening by EPSDT/Healthy Kids providers.
- Dentally necessary treatment or services for the identification of dental problems or the prevention of dental disease.
- Prophylaxis (scaling and coronal polishing) treatment for clients 8 years of age and older. (For clients 7 years of age and under, covered only when billed as a part of oral hygiene instruction.)
- Dental services or treatment necessary for the relief of pain and infections, including removal of symptomatic wisdom teeth. Routine removal of asymptomatic wisdom teeth without justifiable medical indications is not covered.
- Restoration of teeth and maintenance of dental health – with limitations.
- Complex orthodontic treatment for severe handicapping dental needs.
- Complete and partial dentures, and necessary modifications, repairs, rebasing, relining, and adjustments of dentures.
- Dentally necessary oral surgery. Must be coordinated with the client's managed care plan, if any.
- Endodontic (root canals) therapies for permanent teeth except for wisdom teeth.
- Nitrous oxide, only when medically justified and a component of behavior management.

- Crowns – with limitations.
 - Therapeutic pulpotomies.
 - Sealants – with limitations.
3. For clients identified by the department as developmentally disabled, the following preventive services may be allowed more frequently:
- Fluoride application, varnish or gel;
 - Root planing; and
 - Prophylaxis scaling and coronal polishing.
4. Panoramic radiographs are allowed only for oral surgical or orthodontic purposes. They may be covered for diagnostic purposes in emergency situations, when authorization is obtained from MAA within 72 hours of the service.
5. The department covers dentally necessary services provided in a hospital under the direction of a physician or dentist for:
- The care or treatment of teeth, jaws, or structures directly supporting the teeth, if the procedure requires hospitalization; and
 - Short stays when the procedure cannot be done in an office setting.

What is not covered? (WAC 388-535-1100)

1. The dental-related services in this section **are not covered** unless:
 - Required by a physician as a result of an EPSDT/Healthy Kids screen (orthodontic limitations still apply and services must be dentally necessary);
 - Included in a waived program; or
 - Part of one of the Medicare programs for Qualified Medicare Beneficiaries (QMB), except for QMB-Medicare Only which is not covered.

2. MAA does **not cover**:
 - Services, procedures, treatments, devices, drugs, applications or associated services which MAA or the Health Care Financing Administration (HCFA) consider investigative or experimental on the date services are provided.
 - Cosmetic treatment or surgery, except for medically or dentally necessary reconstructive surgery to correct defects attributable to an accident, birth defect, or illness.
 - Teeth whitening.
 - Orthodontic care for:
 - ✓ adults (19 years of age or older);
 - ✓ children (18 years of age or younger) who do not meet the Orthodontic criteria (see fee schedule); or
 - ✓ cosmetic reasons.
 - Any services specifically excluded by statute.
 - More costly services when less costly, equally effective services (as determined by the Department) are available.
 - Non-medical equipment, supplies, personal or comfort items and/or services.
 - Root planing for children (18 years of age or younger), unless clients of the Division of Developmental Disabilities.
 - Root canal services for primary teeth or wisdom teeth.
 - Routine fluoride treatments for adults (19 years of age or older), unless clients of the Division of Developmental Disabilities, or are 65 years or older, with rampant root surface decay and reduced salivary flow.

- Extraction of asymptomatic teeth
 - ✓ Except as a necessary part of Orthodontic treatment; or
 - ✓ Unless their removal is the most cost-effective dental procedure related to dentures.
- Crowns for wisdom teeth.
- Amalgam or acrylic build-up for wisdom teeth.

3. MAA does **not pay** for the following services/supplies:

- Missed or cancelled appointments;
- Provider mileage or travel costs;
- Take-home drugs;
- Dental supplies such as toothbrushes (manual, automatic, or electric), toothpaste, floss, or whiteners;
- Educational supplies;
- Reports, client charts, insurance forms, copying expenses;
- Service charges/delinquent payment fees;
- Dentists' time writing prescriptions or calling in prescriptions or prescription refills to a pharmacy;
- Supplies used in conjunction with an office visit;
- Transitional/immediate dentures;
- Teeth implants (including follow-up and maintenance);
- Bridges;
- Non-emergent oral surgery performed in an inpatient setting (excludes teeth extractions) for adults (19 years of age and older);
- Minor bone grafts; or
- Temporary crowns.

Prior Authorization

Authorization is based on the establishment of dental necessity. When prior authorization is required for a service, MAA will consider requests on a case-by-case basis.

Authorization by MAA indicates only that the specific treatment is dentally necessary. Authorization for dental services does not guarantee payment. (WAC 388-535-1220)

When do I need to get prior authorization?

Authorization must take place before the service is provided.

In an acute emergency, the department *may* authorize the service after it is provided when the department receives justification of dental necessity. This justification must be received by MAA within 72 hours of the emergency service or the next Washington State government business day, whichever is later.

Which services require prior authorization? (WAC 388-535-1220)

The Dental Fee Schedule indicates which services require prior authorization. In the Prior Authorization column:

No	=	Prior Authorization for these services is not required. However, the service must be provided in accordance with the policies indicated for each procedure.
Yes	=	Prior Authorization is required for these services.

Categories of dental and dental-related services that require prior authorization:

- Non-emergent inpatient hospital dental admissions;
- Orthodontic treatment;
- Crowns (other than stainless steel) – see Section J – Crowns;
- Selected procedures identified by MAA – see Fee Schedule (e.g., fluoride application for adults 19-64 years of age); and
- Payment (which may be partial) for laboratory and professional fees for dentures and partials when the client:
 - Dies;
 - Moves from the State of Washington;
 - Cannot be located; or
 - Does not participate in completing the dentures.

How do I get written prior authorization? (WAC 388-535-1220)

- Submit the **ADA Dental Claim Form** listing the services to be provided.
- Include on the claim form:
 - ✓ The client's patient identification code (PIC);
 - ✓ Your name and address;
 - ✓ Your telephone number (including area code); and
 - ✓ Your assigned 7-digit MAA provider number.

(Refer to Section H – Completing the ADA Claim Form.)

- Submit written justification to establish dental necessity for the treatment you intend to provide.

Example

- ✓ Physiological description of the disease, injury, impairment, or other ailment;
 - ✓ X-ray(s);
 - ✓ Treatment plan;
 - ✓ Study model (if requested); and
 - ✓ Photographs (if requested).
- If x-rays are requested or required, make sure they are identified with your name and provider number, so they can be returned to you.
 - If your request is approved by MAA, you will receive the ADA Dental Claim Form with a notation indicating approval or an authorization number. **This original form** is to be completed and submitted for payment. Keep a copy for your records.

Where should I send requests for prior authorization?

Mail your request to:

Quality Utilization Section - Dental
PO Box 45506
Olympia, WA 98504-5506

Billing

What is the time limit for billing? (Refer to WAC 388-502-0150)

MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- **Initial Claims**

- ✓ MAA requires providers to submit an **initial claim** to MAA and obtain an ICN within 365 days from any of the following:
 - The date the provider furnishes the service to the eligible client;
 - The date a final fair hearing decision is entered that impacts the particular claim;
 - The date a court orders MAA to cover the services; or
 - The date DSHS certifies a client eligible under delayed¹ certification criteria.



Note: If MAA has recouped a plan's premium, causing the provider to bill MAA, the time limit is 365 days from the date the plan recouped the payment from the provider.

- ✓ MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:
 - DSHS certification of a client for a retroactive² period; or
 - The provider proves to MAA's satisfaction that there are other extenuating circumstances.
- ✓ MAA requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to MAA's billing limits.

¹ **Delayed Certification:** A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the MAID card. The provider **MUST** refund any payment(s) for a covered service received from the client for the period he/she is determined to be medical assistance-eligible, and then bill MAA for those services.

² **Retroactive Certification:** An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found eligible for the medical service at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill MAA for the service. If the client has not paid for the service and the service is within the client's scope of benefits, providers must bill MAA.

- **Resubmitted Claims**

- ✓ Providers may resubmit, modify, or adjust any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.



Note: MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- The allotted time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.
- The provider, or any agent of the provider, must not bill a client or a client's estate when:
 - ✓ The provider fails to meet these listed requirements; and
 - ✓ MAA does not pay the claim.

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee.

How do I bill for clients eligible for both Medicare and Medicaid?

Medicare does not cover dental procedures. However, surgical CPT procedure codes 10000-69999 must be billed to Medicare first. After receiving Medicare's determination, submit a claim to MAA. Attach a copy of the Medicare determination.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's MAID card. An insurance carrier's time limit for claim submissions may be different from MAA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you haven't received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement;
- If rebilling, also attach a copy of the MAA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the comments field of the Electronic Media Claim (EMC).

Third-party carrier code information is available on the DSHS-MAA web site at <http://maa.dshs.wa.gov>. The information can be used as an on-line reference, downloaded, or printed. If you do not have access to MAA's web site, call 1-800-562-6136 and request that a hard copy or disk be mailed to you.

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What records does MAA require that I keep in a client's file?:

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:
 - ✓ Patient's name and date of birth;
 - ✓ Dates of service(s);
 - ✓ Name and title of person performing the service, if other than the billing practitioner;
 - ✓ Chief complaint or reason for each visit;
 - ✓ Pertinent medical history;
 - ✓ Pertinent findings on examination;
 - ✓ Medications, equipment, and/or supplies prescribed or provided;
 - ✓ Description of treatment (when applicable);
 - ✓ Recommendations for additional treatments, procedures, or consultations;
 - ✓ X-rays, tests, and results;
 - ✓ Dental photographs/teeth models;
 - ✓ Plan of treatment and/or care, and outcome; and
 - ✓ Specific claims and payments received for services.
- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.
- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, for six years from the date of service or longer if required specifically by federal or state law or regulation.

Notifying clients of their rights (advance directives)

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give **all adult clients** written information about their rights, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment;
- Make decisions concerning their own medical care; and
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

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How to Complete the ADA Claim Form

General Information

- Include any required prior authorization number. Prior authorized claim originals must be completed and returned as the billing document.
- Send only one claim form for payment. If the number of services exceeds one claim form, a second form can be submitted. Please make sure that all necessary claim information (provider number, patient identification code, etc.) is repeated on the second form. Each claim form should show the total charges for the services listed.
- **Enter your patient account number in the area directly below the picture of the teeth.**
- These instructions only address those fields that are required for billing MAA.

Send your claims for payment to:

Division of Program Support
PO Box 9253
Olympia WA 98507-9253

Field Description

- | | |
|--|---|
| <p>8. <u>Patient Name:</u> Enter the patient's first name, middle initial (if any), and last name.</p> | <ul style="list-style-type: none"> • Six-digit birthdate, consisting of numerals only (MMDDYY). |
| <p>10. <u>Subscriber/Employee dental plan group number</u></p> | <ul style="list-style-type: none"> • First five letters of the last name (or fewer if the name is less than five letters). • Alpha or numeric character (tiebreaker). |
| <p>12. <u>Date of Birth</u></p> | <p>17. <u>Relationship to Subscriber/Employee:</u> Check the appropriate box.</p> |
| <p>13. <u>Patient ID #:</u> Enter the Patient Identification Code (PIC). MAA identifies clients by this code, not by their name. This is an alphanumeric code assigned to each Medical Assistance client consisting of:</p> <ul style="list-style-type: none"> • First and middle initials (<i>or</i> a dash (-) must be entered if the middle initial is not indicated). | <p>19. <u>Subscriber/Employee ID # SSN #:</u> Enter the dental plan ID # of the employee/subscriber.</p> |
| | <p>20. <u>Employer Name:</u> Enter the name of the subscriber's employer.</p> |

21. **Group no(s):** Enter the group number(s) of the subscriber to the third-party insurance coverage.
22. **Subscriber/Employer Name** (if different from patient's): Enter the name of the employee/subscriber.
28. **Date of Birth:** Enter the birthdate of the employee/subscriber.
31. **Is patient covered by another dental plan?** Check the appropriate response.
32. **Policy #:** If client has third party coverage, indicate the policy # here.
36. **Plan/Program Name**
42. **Name of Billing Dentist or Dental Entity:** Enter the dentist's name or business as recorded with MAA.
43. **Phone Number:** Enter provider's phone number.
44. **Provider ID #:** Enter the provider number assigned to you by MAA when you signed your Core Provider Agreement. It is the same seven-digit number that appears on the MAA Remittance and Status Report in the ***Provider Number*** area at the top of the page. It is this code by which providers are identified, not by provider name. **Without this number, we may be unable to determine the provider and pay the claim.**
- 46, 50, 51, 52: **Address:** Enter the provider's mailing address.

49. **Place of Treatment:** Enter one of the following codes to show the place of service at which the service was performed:

- | | | |
|----------------------|----------|--|
| <u>Office</u> | 3 | dental office or ambulatory surgery center |
| <u>Hosp.</u> | 1 | inpatient hospital |
| | 2 | outpatient hospital |
| | 5 | hospital emergency room |
| <u>ECF</u> | 8 | nursing facility |
| <u>Other</u> | 4 | client's residence |
| | 6 | congregate care facility or group home |

53. **Radiographs or models enclosed?** Check the appropriate box. If you check *yes*, indicate how many X-rays are enclosed.

Note:

- Do not send X-rays when billing for services.
- X-rays are necessary only when prior authorization is being requested.
- Please write "X-rays enclosed" on the mailing envelope and mail to the Quality Utilization Section (see Prior Authorization section for address.)

55. **If prosthesis, is this initial placement?** Enter *yes* or *no*. If *no*, enter reason for replacement and date(s) of extraction(s). If applicable, chart missing teeth for partial(s).

56. **Is treatment result of occupational illness or injury?** Check the appropriate box. If *yes*, describe the illness or injury and list date(s) of occurrence/onset.

57. Is treatment a result of: auto accident? other accident? neither?

Check appropriate box. If *yes*, please describe and give dates.

59. Examination and treatment plan:

Each service performed must be listed as a separate, complete one-line entry except for x-rays which are allowed multiple units. **Each extraction or restoration** must be listed as a separate line entry.

If billing for removable prosthodontics, missing teeth must be noted on the tooth chart.

Date Service Performed: Enter the six-digit date of service, indicating month, day, and year (e.g., April 1, 1999 = 040199).

Tooth # or Letter: Enter the appropriate tooth number, letter(s):

- 01 through 32 for permanent teeth
- A through T for primary teeth
- SN for supernumerary teeth

Quadrants (Q) or Arches (A) must be identified in the **tooth number column** using one of the following two-digit codes:

UR = Upper Right Quadrant
UL = Upper Left Quadrant
LR = Lower Right Quadrant
LL = Lower Left Quadrant
UA = Upper Arch
LA = Lower Arch

Surface: Enter the appropriate code from the list below to indicate the tooth surface worked on. Up to **four codes** may be listed in this column:

M = Mesial
D = Distal
O = Occlusal
I = Incisal

B = Buccal/Labial
F = Facial
A = ALL (mesial, distal occlusal, buccal and lingual)
L = Lingual

Procedure Code: Enter the procedure code from this fee schedule that represents the procedure or service performed. The use of any other procedure code(s) will result in denial of payment.

If procedure codes already indicate multiple surfaces (e.g., composite - two surfaces) *do not* indicate multiple units.

Description of Services: Give a brief written description of the services rendered. When billing for general anesthesia, enter actual beginning and ending times. If you were assisting in surgery, please state “*surgical assist*” here. Next to the description, enter the number of units, if applicable. (*Units* might mean multiple x-rays using the same procedure code; if two x-rays were taken, enter a 2 in this column. If no number is entered, it is assumed that one unit of service was performed.)

If billing for anesthesia, enter *only* the total # of minutes on the claim.

Fee: Enter **your usual and customary fee** (not MAA's maximum allowable rate) for each service rendered.

Total Fee: Total all charges listed.

Payment by other plan: Enter the amount paid by other insurance for these services. Attach the insurance explanation of benefits (EOB) to the claim.

Patient pays: Enter the balance due after insurance.

60. Identify all missing teeth with “X.”

- 61. Remarks for unusual services:** This field is for the nine-digit authorization number assigned for some services by MAA. Enter all nine digits.

This field also may be used for justification for the services rendered, the name of any referring provider or facility, or the name of any provider who administered anesthesia.

Example of Remark: *“Patient fell, broke dentures. Replacement dentures necessary.”*

If you wish to use a medical record number, enter in the remarks area.

- 62. Provider Signature:** Enter the performing provider's number if it is different from the one shown in *field 21*. If you are a dentist in group practice, please indicate your **unique identification number and/or name**.

63-66.

Address where treatment was performed: Complete this section if the treatment was performed at a different location than indicated in #22 and #23.

Primary Teeth Name and Letter

See “scanned” file.

Permanent Teeth Names and Numbers

See “scanned” file.

Dental Fee Schedule

Guide to using the fee schedule

Column 1: Procedure Code (ADA CDT, State-Unique, or CPT™)

Column 2: Description/Limitations

Column 3: Prior Auth? Is prior authorization required?

Column 4: Maximum Allowable – Children 18 years of age or younger.

Column 5: Maximum Allowable – Adults 19 years of age or older.

– OR –

Column 3: Orthodontics – Evaluation & Management (E&M) Codes:
Nonfacility Setting (NFS) Maximum Allowable – Clients all ages.

Column 4: Orthodontics – Evaluation & Management (E&M) Codes:
Facility Setting (FS) Maximum Allowable – Clients all ages.

– OR –

Column 3: Oral Surgery Follow-up Days

Column 4: Assistant Surgeon Allowed?

Column 5: Nonfacility Setting (NFS) Maximum Allowable – Clients all ages.

Column 6: Facility Setting (FS) Maximum Allowable – Clients all ages.

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Dental Program

- Always bill your usual and customary fee(s) (not MAA's maximum allowable amount).
- For certain procedures, there are separate reimbursement rates for children (0 through 18 years of age) and adults (19 years of age or older). These are indicated in the maximum allowable column in the fee schedule.

Note: The MAA Dental Program definition of a child is 18 years of age or younger, which differs from the ADA definition of 13 years of age or younger.

Remember: You may bill only after services have been provided, but we must receive your bill within 365 days from the date of service.

Site of Service (SOS)

Payment Differential

Note: SOS pertains only to CPT™ oral surgery and orthodontic Evaluation and Management (E&M) codes.

Effective with dates of services on or after July 1, 2000, MAA is implementing a Site of Service (SOS) payment differential for professional services, consistent with the Health Care Financing Administration's (HCFA) payment policy. This means there will be distinct maximum allowable fees for professional services performed in facility and non-facility settings.

When will professional services be reimbursed at the Facility Setting (FS) Maximum Allowable Fee?

Providers will be reimbursed at the FS MAF when MAA also makes a payment to a facility. MAA will follow HCFA's determination for using the FS MAF, except when this is not possible due to system limitations.

Professional services billed with the following place of service codes will be reimbursed at the FS MAF:

MAA Place of Service Code	HCFA Place of Service Description
1	Inpatient Hospital
2	Outpatient Hospital
5	Emergency Room – Hospital
8	Skilled Nursing Facility
8	Nursing Facility

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When will professional services be reimbursed at the Non-Facility Setting (NFS) Maximum Allowable Fee?

The NFS MAF is paid when MAA does not make a separate payment to a facility. Services performed in a provider's office, client's home, facility or institution (listed in the following table) will be reimbursed at the NFS MAF. MAA will follow HCFA's determination for using the NFS MAF, except when this is not possible due to system limitations.

Professional services billed with the following place of service codes will be reimbursed at the NFS MAF:

MAA Place of Service Code	HCFA Place of Service Description
3	Office*
4	Home
3	Ambulatory Surgery Center
6	Custodial Care Facility
9	Adult Living Care Facility
3	Federally Qualified Health Center
3	Community Mental Health Center
9	Residential Substance Abuse Treatment Facility
9	Psychiatric Residential Treatment Center
3	State or Local Public Health Clinic`
3	Rural Health Clinic
9	Other Unlisted Facility

*Includes Neurodevelopmental Centers

To summarize:

- **Facility setting maximum allowable fees (FS MAF)** – Paid by MAA when the provider performs the services in a facility setting and cost of the resources are the responsibility of the facility; or
- **Non-facility setting maximum allowable fees (NFS MAF)** – Paid by MAA when the provider performing the service typically bears the cost of resources, such as labor, medical supplies, and medical equipment associated with the service performed.

ADA Procedure Code	Description	Prior Auth?	Maximum Allowable	
			0-18 yrs	19 yrs & up

Diagnostic

Clinical Oral Evaluations

00120	Periodic oral evaluation One periodic evaluation is allowed every six months. An evaluation performed on a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately.	No	\$22.00	\$17.00
00140	Limited oral evaluation An evaluation or reevaluation limited to a specific oral health situation or problem. This code should be used to bill for an evaluation when the dentist is giving limited/emergent services for a specific problem or IS ONLY providing an evaluation for referral and IS NOT providing dental services for the individual. Typically, patients receiving this type of evaluation have been referred for a specific problem and/or present with dental emergencies, trauma, acute infections, etc.	No	\$20.00	\$20.00
00150	Comprehensive oral evaluation For MAA purposes, this is to be considered an initial exam. One initial evaluation allowed per client. Normally used by a general dentist and/or a specialist when evaluating a patient comprehensively. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It may require interpretation of information acquired through additional diagnostic procedures and resulting in a treatment plan. Additional diagnostic procedures should be reported separately. Includes requesting transfer of patient records and establishing the client	No	\$34.00	\$24.00

ADA Procedure Code	Description	Prior Auth?	Maximum Allowable 0-18 yrs	19 yrs & up
	<p>as a patient of record.</p> <p>Includes evaluation and recording of the patient's dental and medical history and a general health assessment. It may typically include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, etc.</p> <p><i>Six months must elapse before a periodic evaluation will be reimbursed.</i></p>			
<p>Limited visual oral assessment</p> <p>Bill for children ages 0 through 18 and adult DDD clients only.</p> <p>Dentists should use this code when:</p> <ul style="list-style-type: none"> ✓ Assessing the need for sealants to be placed by a dental hygienist; ✓ Screening children in Head Start or ECEAP programs; ✓ Providing triage services; or ✓ In circumstances where the child will be referred to another dentist for treatment (the referring dentist will not provide treatment nor provide a full evaluation at the time of the assessment). <p>This code should also be used by public health dental hygienists performing an intraoral screening of soft and hard tissues to assess the need for prophylaxis, sealants, fluoride varnish, or referral for other dental treatments by a dentist. It also includes appropriate referrals, charting patient data and oral health status, and informing the parent or guardian of the results.</p> <p>A limited visual oral health assessment does not replace an oral evaluation by a dentist.</p>				
4420D*	<p>Limited visual oral assessment, low risk Client has no visible dental caries requiring referral for restorative dental intervention.</p>	No	\$10.00	\$10.00 DDD adults only
4421D*	<p>Limited visual oral assessment, moderate risk Client has visible dental caries requiring referral for restorative dental intervention.</p>	No	\$10.00	\$10.00 DDD adults only
4422D*	<p>Limited visual oral assessment, high risk Client has urgent dental disease with visible infection related to caries, with or without pain; requires immediate referral for dental intervention.</p>	No	\$10.00	\$10.00 DDD adults only

*** This is a state-unique code, not an ADA CDT Code.**

ADA Procedure Code	Description	Prior Auth?	Maximum Allowable	
			0-18 yrs	19 yrs & up

Radiographs

00210	Intraoral – complete series (including bitewings) Complete series x-rays will be allowed only once in a 3-year period. A complete intraoral series consists of 14 periapicals and one series of 4 bitewings.	No	\$43.00	\$30.00
00220	Intraoral periapical – single, first film	No	\$7.07	\$6.30
00230	Intraoral periapical – each additional film	No	\$2.02	\$1.05
00240	Intraoral – occlusal, film	No	\$8.08	\$6.30
00270	Bitewing – single film Total of 4 bitewings allowed every 12 months.	No	\$6.06	\$5.25
00272	Bitewings – 2 films Total of 4 bitewings allowed every 12 months	No	\$8.08	\$6.28
00274	Bitewings – 4 films Total of 4 bitewings allowed every 12 months.	No	\$10.10	\$8.40
00321	Temporomandibular joint film	No	\$50.50	\$36.78
00330	<p>Panoramic film – maxilla and mandible</p> <p>Allowable for oral surgical and orthodontic purposes only. Documentation must be entered in the client's file.</p> <p>Panorex, panelipse or orthopantograph are also allowed under this code. Panoramic-type films are allowed once in a 3-year period.</p> <ol style="list-style-type: none"> A shorter interval between panoramic –type x-rays may be allowed for: <ol style="list-style-type: none"> Emergent services, with authorization from MAA within 72 hours of the service; or Oral surgical and orthodontic services, with written prior authorization from MAA. This 3-year time limitation does not apply to preoperative or postoperative surgery cases. <p>Doing <u>both</u> a panoramic film and an intraoral complete series is not allowed. Up to 4 bitewings will be allowed in addition to a panoramic film.</p>	No	\$43.00	\$22.07

ADA Procedure Code	Description	Prior Auth?	Maximum Allowable	
			0-18 yrs	19 yrs & up

Test and Laboratory Examination

00460	Pulp vitality test Allowed one time per day with justification. Tooth designation required.	No	\$12.12	\$8.40
00501	Histopathologic examination Histological examination of oral hard/soft tissue.	No	\$42.42	\$40.98

ADA Procedure Code	Description	Prior Auth?	Maximum Allowable	
			0-18 yrs	19 yrs & up

Preventive

Prophylaxis (Scaling and coronal polishing)

<ul style="list-style-type: none"> No additional allowance will be given for a cavitron or ultrasonic scaling. Prophylaxis and topical application of fluoride must be billed separately. Prophylaxis treatment is allowed once every twelve months for nursing facility clients whose care is supplemented by mouth care from the nursing facility staff. 				
01110	Prophylaxis, adult age 19 and up Allowed once every twelve months. A treatment performed on permanent dentition which includes scaling and polishing procedures to remove coronal plaque, calculus, and stains.	No	Not Covered	\$31.53
01120	Prophylaxis, child age 8-18 Allowed once every six months. Rubber cup or bristle prophylaxis is not the standard of care for children under 8 years of age, unless developmentally disabled (see state unique procedure code 0113D) or provided under ADA CDT code 01330 or state unique procedure code 4112D.	No	\$23.23 (8-18 years only)	Use Code Above
0113D*	Prophylaxis for developmentally disabled (DDD) clients only. Allowed 3 times, per calendar year.	No	\$40.00	\$40.00
01330	Oral hygiene instructions Allowed once per calendar year for children 0 through 7 years of age. May include rubber cup, bristle or toothbrush prophylaxis. Clients may not be charged separately for a rubber cup, bristle, or toothbrush prophylaxis.	No	\$15.15 (0-7 years only)	Not Covered
4112D*	Second oral hygiene instructions Allowed once per calendar year for children 0 through 7 years of age. May include rubber cup, bristle or toothbrush prophylaxis. Clients may not be charged separately for a rubber cup, bristle, or toothbrush prophylaxis.	No	\$5.05 (0-7 years only)	Not Covered

* Not an ADA CDT Code

ADA Procedure Code	Description	Prior Auth?	Maximum Allowable 0-18 yrs 19 yrs & up
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Fluoride Treatments

- Fluoride treatments are not covered as a routine adult service for persons 19-64 years of age. This service requires prior authorization for this age group, unless provided to a DDD client.
- Document in the client's file which material (e.g., topical gel or fluoride varnish) is used.
- Either topical application of fluoride gel or fluoride varnish will be paid, but not both.

01203	Topical application of fluoride – one treatment (excluding prophylaxis). (Use procedure code 0121D for DDD clients.) Allowed once every 6 months. Additional applications may be reimbursed with prior authorization.	No	\$13.39	
	Effective with dates of service on or after July 1, 2000 , high-risk adults 65 years of age and older are covered. High-risk adult is defined as 65 years or older with rampant root surface decay and reduced salivary flow (xerostomia). The dryness of the mouth may be drug-induced, brought on by the aging process, or a sign or symptom of a systemic disease.	No		\$8.00 High-risk adults Age 65 and older
	Effective with dates of service on or after July 1, 2000 , fluoride application for adults 19-64 years of age with rampant root surface decay and xerostomia, or specific diagnosis such as HIV/AIDS, may be covered with prior authorization.	Yes		\$8.00 High-risk adults 19-64 years old
0121D*	Topical application of fluoride for DDD clients – one treatment (excluding prophylaxis) Allowed 3 times in a calendar year.	No	\$13.39 DDD clients only	\$13.39 DDD clients only
0122D*	Application of fluoride varnish Allowed up to three times in a 12-month period.	No	\$18.54	\$18.54 DDD clients only

* Not an ADA CDT Code

ADA Procedure Code	Description	Prior Auth?	Maximum Allowable	
			0-18 yrs	19 yrs & up

Other Preventive Services

- Sealants may be applied to occlusal surfaces of primary and permanent maxillary and mandibular first and second molars and lingual pits of teeth 7 and 10.
- Only teeth with no proximal decay will be covered.
- Sealants are restricted to children 0 through 18 years of age.
- The application of pit and fissure sealants will be covered only once per tooth in a 3-year period.

01351	Topical application of sealants – per tooth Tooth and surface designations required. Includes glass ionomer sealants.	No	\$22.22	Not Covered
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ADA Procedure Code	Description	Prior Auth?	Maximum Allowable	
			0-18 yrs	19 yrs & up

Space Management Therapy

Space maintainers will be allowed as follows:

- To hold space for missing first and/or second primary molars. Space maintainers are allowed for maintaining positioning for permanent teeth for spaces A, B, I, J, K, L, S and T for clients 18 years of age and under.
- No additional allowance will be given on a lingual arch space maintainer for 3 teeth.
- No reimbursement will be allowed for removing retainers.
- Vertical space maintainers are not covered.

01510	Fixed – unilateral type Allowed only once per quadrant. Quadrant designation required.	No	\$80.80	Not Covered
01515	Fixed – bilateral type Allowed only once per arch. Arch designation required.	No	\$121.20	Not Covered
01550	Recementation of space maintainer Allowed once per quadrant or arch. Quadrant or arch designation required.	No	\$28.28	Not Covered

ADA Procedure Code	Description	Prior Auth?	Maximum Allowable	
			0-18 yrs	19 yrs & up

Restorative

- Multiple restorations of the same surface of tooth are considered as a single surface.
- Reimbursement for all pit restorations is allowed as though for one surface amalgam.
- Bases and polishing amalgams are included in the allowance for the major restoration.
- Amalgams and composite restorations are covered only once in a 2-year period. This applies only to the same surface of the same tooth. If this surface is redone with an additional adjoining surface, all restored surfaces will be covered. Replacement within a 2-year period requires written justification on claim form and in patient record.
- Composite restorations are only allowed on:

Anterior permanent teeth 6 through 11;
Anterior permanent teeth 22 through 27;
Anterior primary teeth C through H; and
Anterior primary teeth M through R.

Composite restorations on posterior teeth are automatically paid at the same allowable as the corresponding amalgam.

Amalgam Restorations (including polishing)

Limit of 6 surfaces per tooth in any combination of the following codes.				
02110	Amalgam – 1 surface, primary Tooth and surface designations required.	No	\$50.50	\$24.17
02120	Amalgam – 2 surface, primary Tooth and surface designations required.	No	\$62.62	\$34.68
02130	Amalgam – 3 (or more) surfaces, primary It is anticipated that a stainless steel crown would be considered rather than 4 amalgam restorations on a primary tooth. Tooth and surface designations required.	No	\$70.70	\$39.93
02140	Amalgam – 1 surface, permanent Tooth and surface designations required.	No	\$50.50	\$36.06
02150	Amalgam – 2 surfaces, permanent Tooth and surface designations required.	No	\$62.62	\$48.42
02160	Amalgam – 3 surfaces, permanent Tooth and surface designations required.	No	\$70.70	\$59.75
02161	Amalgam – 4 or more surfaces, permanent Tooth and surface designations required.	No	\$70.70	\$70.40

ADA Procedure Code	Description	Prior Auth?	Maximum Allowable	
			0-18 yrs	19 yrs & up

Resin Restorations (Composite/Glass Ionomer)

Limit of 6 surfaces per tooth in any combination of the following codes.				
02330	Resin – 1 surface, anterior, primary or permanent Tooth and surface designations required.	No	\$60.00	\$34.68
02331	Resin – 2 surfaces, anterior, primary or permanent Tooth and surface designations required.	No	\$65.65	\$52.54
02332	Resin – 3 surfaces, anterior, primary or permanent Tooth and surface designations required.	No	\$70.70	\$67.25
02335	Resin – 4 or more surfaces or involving incisal angle (anterior) Tooth and surface designations required.	No	\$70.70	\$79.87
02336	Composite resin crown, anterior – primary. Tooth designation required.	No	\$95.00	\$53.59
02380	Resin – 1 surface, posterior – primary Tooth and surface designations required.	No	\$50.50	\$24.17
02381	Resin – 2 surface, posterior-primary Tooth and surface designations required.	No	\$62.62	\$34.68
02382	Resin – 3 or more surfaces, posterior-primary Tooth and surface designations required.	No	\$70.70	\$39.93
02385	Resin – 1 surface, posterior-permanent Tooth and surface designations required.	No	\$50.50	\$36.06
02386	Resin – 2 surfaces, posterior-permanent Tooth and surface designations required.	No	\$62.62	\$48.42
02387	Resin – 3 or more surfaces, posterior-permanent Tooth and surface designations required.	No	\$70.70	\$59.75

Crowns


Use the final seating date, not the preparation date,
as the date of service.

Criteria for crowns

- Crowns must be dentally necessary as in Definitions in Section B.
- Coverage is based upon a supportable five-year prognosis that the client will retain the tooth if crowned.

The provider must submit the following information:

- ✓ The overall condition of the mouth;
 - ✓ Oral health status;
 - ✓ Assessment of patient's ability to maintain good oral health;
 - ✓ Arch integrity; and
 - ✓ Prognosis of remaining teeth (that is, no more involved than periodontal case type II).
- Anterior teeth must show traumatic or pathological destruction to loss of at least one incisal angle.

 **Note:** The fee for crowns includes tooth and soft tissue preparation and seating, amalgam or acrylic build-ups, temporary restoration, cement base, insulating bases, impressions, and local anesthesia.

Crowns not requiring prior authorization

The following crowns do not need authorization and are covered:

- Stainless steel; and
- Non-laboratory resin for primary anterior teeth.

Crowns that require prior authorization

Laboratory Processed Crowns

- The following laboratory processed crowns require prior authorization and are limited to single restoration for permanent anterior teeth (upper, 6, 7, 8, 9, 10, and 11 and lower 22, 23, 24, 25, 26, and 27), as follows:
 - ✓ Porcelain fused to high noble metal;
 - ✓ Porcelain fused to predominately base metal;
 - ✓ Porcelain fused to noble metal;
 - ✓ Porcelain/ceramic substrate;
 - ✓ Full cast high noble metal;
 - ✓ Full cast predominantly base metal;
 - ✓ Full cast noble metal; and
 - ✓ Resin (laboratory)
- Are covered only once per permanent tooth in a five-year period;
- Are covered for endodontically-treated anterior teeth only after satisfactory completion of the root canal therapy. Post-endodontic treatment X-rays must be submitted for prior authorization of these crowns;
- Are covered when a lesser service will not suffice because of extensive coronal destruction, and treatment is beyond intracoronar restoration; and
- Are not covered for upper posterior teeth (1, 2, 3, 4, 5, 12, 13, 14, 15, and 16) or for lower posterior teeth (17, 18, 19, 20, 21, 28, 29, 30, 31, and 32).

Radiographs may be requested by MAA for confirmation that the requested service meets criteria.

ADA Procedure Code	Description	Prior Auth?	Maximum Allowable	
			0-18 yrs	19 yrs & up
Prior authorization is required for many of the following crowns. Payment will be denied for claims without prior authorization.				
02336	Composite resin crown, anterior-primary Tooth designation required.	No	\$70.70	\$53.59
02710	Crown – resin (laboratory) Tooth designation required. Covered for upper & lower permanent anterior teeth only.	Yes	\$119.18	\$121.56
02740	Crown – porcelain/ceramic substrate Tooth designation required. Covered for upper & lower permanent anterior teeth only.	Yes	\$303.00	\$309.06
02750	Crown – porcelain fused to high noble metal Tooth designation required. Covered for upper & lower permanent anterior teeth only.	Yes	\$303.00	\$309.06
02751	Crown – porcelain fused to predominantly base metal Tooth designation required. Covered for upper & lower permanent anterior teeth only.	Yes	\$303.00	\$309.06
02752	Crown – porcelain fused to noble metal Tooth designation required. Covered for upper & lower permanent anterior teeth only.	Yes	\$303.00	\$309.06
02790	Crown – full cast high noble metal Tooth designation required. Covered for upper & lower permanent anterior teeth only.	Yes	\$303.00	\$309.06
02791	Crown – full cast predominantly base metal Tooth designation required. Covered for upper & lower permanent anterior teeth only.	Yes	\$303.00	\$309.06
02792	Crown – full cast noble metal Tooth designation required. Covered for upper & lower permanent anterior teeth only.	Yes	\$303.00	\$309.06

Other Restorative Services

02910	Recement inlays Tooth designation required.	No	\$17.17	\$16.81
02920	Recement crown Tooth designation required.	No	\$20.20	\$16.81
02930	Prefabricated stainless steel crown – primary tooth Tooth designation required.	No	\$90.00	\$53.59
02931	Prefabricated stainless steel crown – permanent tooth Tooth designation required.	No	\$90.00	\$58.84

ADA Procedure Code	Description	Prior Auth?	Maximum Allowable	
			0-18 yrs	19 yrs & up

Endodontic

Pulpotomy (excluding final restoration)

03220	Therapeutic pulpotomy Covered only as complete procedure, once per tooth. Tooth designation required.	No	\$44.44	\$35.73
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Root Canal Therapy

<ul style="list-style-type: none"> Includes treatment plan, x-rays, clinical procedures and follow-up care. Separate charges are allowable for open and drain and for root canal treatments if the procedures are done on different days. Not covered for primary teeth. ADA-CDT code 03330 is not covered for wisdom teeth. 				
03310	Anterior (excludes final restoration) Tooth designation required. Not covered for primary teeth.	No	\$250.00	\$139.76
03320	Bicuspid (excludes final restoration) Tooth designation required. Not covered for primary teeth.	No	\$252.50	\$194.40
03330	Molar (excludes final restoration) Tooth designation required. Not covered for primary teeth or wisdom teeth.	No	\$282.80	\$216.34

Apexification/Recalcification Procedures

<ul style="list-style-type: none"> Not covered on primary teeth. 				
03351	Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.) Includes opening tooth, pulpectomy, preparation of canal spaces, first placement of medication and necessary radiographs. (This procedure includes first phase of complete root canal therapy.) Tooth designation required.	No	\$70.70	\$41.21

ADA Procedure Code	Description	Prior Auth?	Maximum Allowable	
			0-18 yrs	19 yrs & up
03352	Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.) For visits in which the intra-canal medication is replaced with new medication and necessary radiographs. There may be several of these visits. MAA pays up to five (5) dentally necessary visits. Tooth designation required.	No	\$35.35	\$26.28

ADA Procedure Code	Description	Prior Auth?	Maximum Allowable	
			0-18 yrs	19 yrs & up

Apexification/Periradicular Services

<ul style="list-style-type: none"> Not covered on primary teeth 				
03410	Apicoectomy/periradicular surgery – anterior For surgery on root of anterior tooth. Does not include placement of retrograde filling material. Tooth designation required.	No	\$156.55	\$136.61
03421	Apicoectomy/periradicular surgery – bicuspid (first root) For surgery on one root of a bicuspid. Does not include placement of retrograde filling material. If more than one root is treated, see 03426. Tooth designation required.	No	\$156.55	\$136.61
03425	Apicoectomy/periradicular surgery – molar (first root) For surgery on one root of a molar tooth. Does not include placement of retrograde filling material. If more than one root is treated, see 03426. Tooth designation required.	No	\$156.55	\$136.61
03426	Apicoectomy/periradicular surgery (each additional root) Typically used for bicuspid and molar surgeries when more than one root is treated during the same procedure. This does not include placement of retrograde filling material. Tooth designation required.	No	\$47.47	\$46.24
03430	Retrograde filling, per root Only covered if done with apicoectomy. Tooth designation required.	No	\$46.46	\$27.33

Other Endodontic Procedures

<ul style="list-style-type: none"> Anterior primary teeth are not covered 				
03950	Canal preparation and fitting of preformed dowel or post. (MAA covers only the dowel or post portion of this procedure.) Maximum of three per tooth allowed. Tooth designation required.	No	\$25.25	\$22.07

ADA Procedure Code	Description	Prior Auth?	Maximum Allowable	
			0-18 yrs	19 yrs & up

Periodontics

Surgical Services

04210	Gingivectomy or gingivoplasty Gingivectomy, maximum per quadrant. Gingivoplasty not covered. Quadrant designation required.	No	\$101.00	\$52.54
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- Periodontal scaling and root planing is allowed when the patient has radiographic evidence of periodontal disease, with at least 4mm pocketing.
- Ultrasonic scaling/gross scaling does not qualify for a separate fee; it is included in other periodontal procedures.
- Root planing is covered once per quadrant in a 24-month period.
- **Not covered for clients 0-18 years of age unless DDD client.**
Root planing is covered every 6 months for DDD clients.
- Quadrant designation required. Adequate supporting documentation including pocket depth charting and a definitive periodontal diagnosis must be available to MAA.

04341	Periodontal scaling and root planing (5-8 teeth, per quadrant)	No	\$25.76 DDD clients only	\$26.28
0435D*	Periodontal scaling and root planing (1-4 teeth, per quadrant)	No	\$13.39 DDD clients only	\$13.66

* Not an ADA CDT Code

Prosthodontics, Removable

Use the seating date to bill for dentures.

Exception

The impression date may be used as the service date for dentures, including partials, only when:

- Related dental services, including laboratory services, were provided during a client's eligible period; and
- The client is not eligible at the time of delivery.

Initial Placement of Complete Dentures

Upper and/or lower complete dentures placed after extraction of teeth do not require prior authorization.

Replacement of Complete or Partial Dentures

Prior authorization for replacement of complete or partial dentures is not required when:

- Client's existing dentures are no longer serviceable and cannot be relined, rebased, are lost or damaged beyond repair;
- Client has been able to wear dentures successfully; and
- The denture meets the criteria of dentally necessary.

Required Documentation for Complete and Partial Dentures

To justify replacement of complete or partial dentures:

1. Document the justification for replacement of dentures in the client's record; **and**
2. For partial dentures, chart the **missing teeth** on the claim form **and** in the client's record; **and**
3. In the "Remarks for Unusual Services" field on the ADA claim form, write the justification for replacement of complete or partial dentures; or
4. If billing electronically, enter the justification in the "Comments/Remarks" field.

Noncovered Services

The following related denture services are not covered:

- Provision of dentures for *cosmetic* purposes; and
- Extraction of *asymptomatic teeth*, unless their removal constitutes the most cost effective dental procedure for the provision of dentures.

Dentures, partial dentures and rebased dentures require labeling in accordance with state law.

ADA Procedure Code	Description	Prior Auth?	Maximum Allowable	
			0-18 yrs	19 yrs & up

Complete Dentures (including 6 months post-delivery care)

<ul style="list-style-type: none"> Upper and/or lower complete dentures placed after extraction of teeth <u>do not require prior authorization</u>. The MAA dental program covers one set of dentures in a ten-year period. Dentures placed immediately must be of structure and quality to be considered the permanent set. <u>Transitional or treatment dentures are not covered</u>. No additional reimbursement is allowed for <i>denture insertions</i>. 				
05110	Complete upper	No	\$365.72	\$346.77
05120	Complete lower	No	\$365.72	\$346.77
0515D*	Dentures/partials where patient died, moved, etc. Laboratory and professional fees may be paid for full or partial dentures if the patient <ul style="list-style-type: none"> Dies; Moves from the state; Cannot be located; or Does not participate in completing the dentures. Invoice must be attached listing lab and professional fees.	Yes	By Report	By Report

Partial Dentures (including 6 months post-delivery care)

<ul style="list-style-type: none"> One partial per arch is covered. Cast Base Partial Dentures (procedure codes 05213 and 05214) are covered only when replacing 3 or more teeth per arch, excluding wisdom teeth (tooth numbers 1, 16, 17, and 32). Resin Base Partial Dentures (procedure codes 05211 and 05212) are covered, excluding wisdom teeth (tooth numbers 1, 16, 17, and 32). MAA pays for partials covered by MAA once in 5 years. Laboratory and professional fees are paid under procedure code 0515D*. 				
05211	Maxillary partial denture – resin base (or all acrylic) Includes any conventional clasps, rests and teeth.	No	\$155.56	\$147.11

* Not an ADA CDT Code

ADA Procedure Code	Description	Prior Auth?	Maximum Allowable	
			0-18 yrs	19 yrs & up
05212	Mandibular partial denture – resin base (or all acrylic) Includes any conventional clasps, rests and teeth.	No	\$155.56	\$147.11
05213	Maxillary partial denture – cast metal framework with resin denture bases. Includes any conventional clasps, rests and teeth.	No	\$328.25	\$334.82
05214	Mandibular partial denture – cast metal framework with resin denture bases. Includes any conventional clasps, rests and teeth.	No	\$328.25	\$334.82

* Not an ADA CDT Code

ADA Procedure Code	Description	Prior Auth?	Maximum Allowable	
			0-18 yrs	19 yrs & up

Adjustments to Dentures and Partial

<ul style="list-style-type: none"> No allowance for adjustments for 6 months following placement. Adjustments done during this period are included in denture/partial allowance. 				
05410	Complete denture, upper	No	\$16.48	\$15.76
05411	Complete denture, lower	No	\$16.48	\$15.76
05421	Partial denture, upper	No	\$16.48	\$15.76
05422	Partial denture, lower	No	\$16.48	\$15.76

Repairs to Complete Dentures

05510	Repair broken complete denture base Arch designation required.	No	\$37.09	\$34.68
05520	Replace missing or broken teeth – complete denture Use for initial teeth. Tooth designation required.	No	\$32.97	\$31.53
0552D*	Each additional tooth Tooth designation required.	No	\$9.27	\$8.40

Repairs to Partial Dentures

05610	Repair acrylic saddle or base (partial denture) Arch designation required.	No	\$34.00	\$32.58
05630	Repair or replace broken clasp Arch designation required.	No	\$51.51	\$48.34
05640	Replace broken teeth Use for initial tooth. Tooth designation required.	No	\$32.97	\$31.53
0565D*	Each additional tooth Tooth designation required.	No	\$9.27	\$8.40
05650	Add tooth to partial denture to replace extracted tooth; each tooth. Does not involve clasp or abutment tooth. Tooth designation required.	No	\$39.15	\$36.78
05660	Add clasp to partial denture to replace extracted tooth; each tooth. Involves clasp or abutment tooth. Tooth designation required.	No	\$87.57	\$83.02

* Not an ADA CDT Code

ADA Procedure Code	Description	Prior Auth?	Maximum Allowable	
			0-18 yrs	19 yrs & up

Denture Rebase Procedures

05710	Rebase complete upper Requires justification (e.g., lost vertical dimension, incorrect bite). Original dentures must be at least 3 years old. Rebase allowed once in a 5 year period.	No	\$190.59	\$180.74
05711	Rebase complete lower Requires justification (e.g., lost vertical dimension, incorrect bite). Original dentures must be at least 3 years old. Rebase allowed once in a 5 year period.	No	\$190.59	\$180.74
05720	Rebase upper partial denture Requires justification (e.g., lost vertical dimension, incorrect bite). Original dentures must be at least 3 years old. Rebase allowed once in a 5 year period.	No	\$123.62	\$116.64
05721	Rebase lower partial denture Requires justification (e.g., lost vertical dimension, incorrect bite). Original dentures must be at least 3 years old. Rebase allowed once in a 5 year period.	No	\$123.62	\$116.64

Denture Relining

<ul style="list-style-type: none"> Relines are included in allowance for dentures if service is provided within first six months of placement of dentures. Reline of partial or full dentures is not allowed more than once in a 5-year period. 				
05750	Reline complete maxillary denture (laboratory)	No	\$111.26	\$105.08
05751	Reline complete mandibular denture (laboratory)	No	\$111.26	\$105.08
05760	Reline maxillary partial denture (laboratory)	No	\$101.99	\$96.68
05761	Reline mandibular partial denture (laboratory)	No	\$101.99	\$96.68

Other Prosthetic Services

05850	Tissue conditioning, maxillary Included in allowance for dentures if service is provided within first six months of placement of dentures.	No	\$19.57	\$18.91
05851	Tissue conditioning, mandibular Included in allowance for dentures if service is provided within first six months of placement of dentures.	No	\$19.57	\$18.91
05932	Obturator prosthesis, definitive	No	\$544.98	\$515.95

Dental Program

ADA Procedure Code	Description	Prior Auth?	Maximum Allowable	
			0-18 yrs	19 yrs & up
05933	Obturator prosthesis, modification	No	\$120.00	Not Covered
05952	Speech aid prosthesis, pediatric	No	\$762.35	\$721.91

ADA Procedure Code	Description	Prior Auth?	Maximum Allowable	
			0-18 yrs	19 yrs & up

Prosthodontics, Fixed Repairs

0663D*	Replace, repair, or fabricate broken facing Tooth designation required.	No	\$70.05	\$66.20
06930	Recement fixed partial denture (bridge)	No	\$34.00	\$32.58

Management of Temporomandibular Joint Dysfunction

07880	Occlusal orthotic appliance TMJ night guard splint or if the client has a medical diagnosis of bruxism [grinding of the teeth]. The maximum allowance includes all professional fees, lab costs for splint, and all required follow-ups. One appliance allowed in a two-year period.	No	\$163.62	\$157.62
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* Not an ADA CDT Code

ADA Procedure Code	Description	Prior Auth?	Maximum Allowable	
			0-18 yrs	19 yrs & up

Oral Surgery – Dentists

Includes Preoperative and Postoperative Treatment

MAA covers medically necessary services provided in a hospital in connection with the care and treatment of teeth, jaws, or structure directly supporting the teeth, if the procedure requires hospitalization in connection with the provision of such services. Services covered under this section must be furnished under the direction of a physician or a dentist. (WAC 388-556-0400)

Simple Extraction (includes local anesthesia and routine postoperative care)

07110	Single tooth (initial) Tooth designation required.	No	\$78.46	\$41.00
07120	Each additional tooth (same day) regardless of quadrant Tooth designation required.	No	\$24.24	\$25.22
07130	Root removal exposed roots Example: Patient with missing crown. Tooth designation required.	No	\$37.37	\$30.48

Surgical Extractions (includes local anesthesia and routine postoperative care)

07210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth prior to removal of tooth. Tooth designation required.	No	\$90.00	\$59.89
07220	Removal of impacted tooth-soft tissue Impaction that requires incisions of overlying soft tissue and the removal of the tooth. Tooth designation required.	No	\$90.90	\$76.71
07230	Removal of impacted tooth-partially bony Impaction that requires incisions of overlying soft tissue, elevation of a flap, removal of bone, and the removal of the tooth. Tooth designation required.	No	\$111.10	\$104.03
07240	Removal of impacted tooth-completely bony Impaction that requires incision of overlying soft tissue, elevation of a flap, removal of bone, and sectioning of the tooth for removal. Allowed only when pathology is present. Tooth designation required.	No	\$146.45	\$132.41

ADA Procedure Code	Description	Prior Auth?	Maximum Allowable	
			0-18 yrs	19 yrs & up
07241	Removal of impacted tooth-completely bony, with unusual surgical complications. Impaction that requires incision of overlying soft tissue, elevation of flap, removal of bone, sectioning of the tooth for removal, and/or presents unusual difficulties and circumstances. Allowed only when pathology is present. Tooth designation required.	No	\$191.90	\$140.81
07250	Root recovery (surgical removal of residual root) Tooth designation required.	No	\$80.80	\$48.34
07270	Tooth reimplantation and/or stabilization Permanent teeth only. Tooth designation required.	No	\$106.05	\$78.82

Other Surgical Procedures

07280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons. Includes orthodontic attachments. Tooth designation required; limited to clients 18 years of age and under.	No	\$154.53	Not Covered
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Orthodontics

What is covered by MAA?

- Complex orthodontic treatment for severe handicapping dental needs is covered subject to the limits of this section; and
- Selected Evaluation and Management (E&M) procedure codes, as listed on pages K16 through K22, related to specific diagnoses listed on page K23.

Who is eligible?

Complex orthodontic treatment for severe handicapping dental needs is available for children (18 years of age and younger) whose Medical Assistance IDentification (MAID) card bears one of the following identifiers:

- **CNP** (Categorically Needy Program)
- **CNP-CHIP** (CNP-Children's Health Insurance Program)
- **LCP-MNP** (Limited Casualty Program – Medically Needy Program)
- **Children's Health**

Is written prior authorization required?

Yes! Orthodontic care for **severe malocclusions** must be prior authorized by MAA.

- Orthodontists may use the Expedited Prior Authorization (EPA) process defined in Numbered Memorandum 99-59 (or current version – see <http://maa.dshs.wa.gov>, Numbered Memos 2000 link).
- Dentists must submit a written request for prior authorization to MAA.

Exception

Prior authorization is not required for clients with cleft lip, cleft palate or craniofacial anomalies when the eligible client is being treated by an orthodontist who is a member of an MAA-recognized cleft lip, cleft palate or craniofacial anomaly case management team.

What are MAA's criteria for orthodontic services?

To be eligible for orthodontic care, a client must be eligible for EPSDT/Healthy Kids and meet one of the following categories:

- A child with clefts (lip and/or palate) and congenital or acquired craniofacial anomalies, when case-managed by an MAA-recognized cleft lip, cleft palate, or craniofacial team for:
 - ✓ Cleft lip and palate, cleft palate or cleft lip with alveolar process involvement;
 - ✓ Craniofacial anomalies, including but not limited to:
 - Hemifacial microsomia;
 - Craniosynostosis syndromes;
 - Cleidocranial dysplasia;
 - Arthrogryposis;
 - Marfans syndrome; or
 - Other syndromes by MAA review.
 - ✓ Other diseases/dysplasia with significant facial growth impact, e.g., juvenile rheumatoid arthritis (JRA); or
 - ✓ Post traumatic, post radiation, or post burn jaw deformity;
- Note:** MAA or the Office of Children with Special Health Care Needs (OCSHCN) does not require written prior authorization for services to a client with cleft palate and/or craniofacial anomalies when the client is case-managed by an MAA-recognized cleft palate and/or craniofacial team that has a Special Agreement with MAA.
- A child with severe malocclusions which include one or more of the following:
 - ✓ A severe skeletal disharmony;
 - ✓ A severe overjet resulting in functional impairment; or
 - ✓ A severe vertical overbite resulting in palatal impingement and/or damage to the mandibular labial tissues of the oral cavity;
- A child with other dental malformations resulting in severe dental functional impairment. MAA reviews each of these cases for dental necessity.

Orthodontic treatment

MAA's payment includes the initial necessary retainers and appliance removal. MAA does not cover lost or broken orthodontic appliances.

- MAA covers interceptive orthodontic treatment once in a client's lifetime for clients with cleft palate, craniofacial anomaly, or severe malocclusions.
- MAA covers limited transitional orthodontic care for a maximum of one year from original placement. MAA allows follow up treatments in three-month increments after the initial appliance placement.
- MAA limits full orthodontic care to a maximum of two years from original appliance placement. MAA allows six follow-up treatments in three-month increments, beginning six months after original appliance placement. MAA may allow, with written prior authorization, two additional follow-up treatments for clients who have not had limited transitional orthodontic treatment.

What about orthodontic treatment beyond the client's eligibility period?

MAA requires written prior authorization for orthodontic care, unless specified otherwise. Frequently, orthodontic care extends over many months. Make certain that the client or the client's guardian fully understands that if eligibility for dental benefits ends before the conclusion of the orthodontic treatment, payment for any remaining treatments will be his/her responsibility.

When do I need to fill out the Orthodontic Information Sheet?

Any time orthodontic services are requested for an MAA client, you must complete the Orthodontic Information sheet. See page K6 for instructions on filling out the Orthodontic Information sheet and submitting any necessary photos. **Page K7 contains a copy of the Orthodontic Information sheet for you to copy and use as necessary.**

Orthodontic Examination Fee

Bill your fee for the orthodontic examination using the appropriate procedure code. Submit this information on the dental claim form at the same time you submit the *Orthodontic Information* sheet.

Orthodontic Examination Review Results from MAA

The MAA orthodontic consultant will review the photos and all of the information you submit for each case and will return the *Orthodontic Information* sheet to you with one of the following indications:

- _____ Orthodontic case study and treatment authorized.
- _____ Orthodontic case study authorized. *Treatment is not authorized at this time.*
Submit case study for evaluation.
- _____ Request for orthodontic case study denied. See comments below.
- _____ See comments below.

Submitting Additional Information

If your initial submission is not authorized for treatment, you must send MAA the following if you are requesting re-evaluation:

- Claim for the full case study attached to the Orthodontic Information sheet; and
- Appropriate X-rays, e.g., panoramic and cephalometric radiographs.

A separate letter with any additional information may be included in your submission if it will contribute information that may affect MAA's final decision.

On your ADA claim form, be sure to include the prior authorization number assigned by MAA. Copy the number as listed on Part 1 of the Orthodontic Information sheet.

Study Models

If MAA finds the additional information insufficient to authorize treatment, MAA may request study models. **Do not send study models unless they are requested.**

When do I bill?

Limited Orthodontic Treatment

1. **First Billing:** When limited orthodontic treatment is authorized, you should bill MAA at the time you place the appliance. The initial reimbursement will include placement of the appliance and the first quarter of active treatment.
2. **Subsequent Billing:**
 - ✓ After the original three months of treatment, you must bill subsequent treatments in three-month segments.
 - ✓ **Services must be billed at the end of the three-month period.** For billing purposes, use a date towards the end of the three-month period as the date of service.
 - ✓ Services billed using earlier dates in the three-month period may be denied payment.
 - ✓ Document the actual service dates in the client's record.
3. **Total Care Maximum:** MAA reimburses up to one year of total care from the date of the original placing of appliances. MAA does not authorize extensions for limited transitional orthodontic treatment.

Full Orthodontic Treatment

1. **First Billing:** When full orthodontic treatment is authorized, you should bill MAA at the time of the placing of the appliance. **The initial reimbursement includes placement of the appliance(s) and the first six (6) months of active treatment.**
2. **Subsequent Billing:**
 - ✓ After the original six months of treatment, you must bill subsequent treatments in three-month segments.
 - ✓ Services must be billed at the end of the three-month period, using a date towards the end of the three-month period as the date of service for billing purposes.
 - ✓ Services billed using earlier dates in the three-month period may be denied payment.
 - ✓ Document the actual service dates in the client's record.
 - ✓ Indicate the date of the original appliance placement in field 35 of the ADA claim form.
3. **Total Care Maximum:** MAA reimburses a maximum of two years of total care from the date of the original appliance placement, unless the client has reached age 19 and is no longer eligible. Treatment for clients who have had no limited transitional orthodontic care may be extended with prior written authorization.

Orthodontic Information Sheet

(To be completed by the performing orthodontist or dentist.)

Follow steps 1 and 2 below when applying for authorization to provide orthodontic services:

1. Complete the Orthodontic Information sheet

- a) Fill in the *provider information* and *patient information* sections at the top of the sheet.
- b) In Part 1, fill in the information requested in each area that applies to the treatment being provided.
- c) In Part 2, fill in as much as possible to assist MAA's orthodontic consultant in determining medical/dental necessity.

2. Submit the following full set of 8 dental photographs to MAA:

a) Intraoral Dental Photographs:

- 1) Anterior (teeth in centric occlusion)
- 2) Right lateral (teeth in centric occlusion)
- 3) Left lateral (teeth in centric occlusion)
- 4) Upper Occlusal View (taken using a mirror)
- 5) Lower Occlusal View (taken using a mirror)

b) Extraoral Photographs:

- 1) Frontal
- 2) Frontal Smiling
- 3) Lateral Profile

Mailing Address:

Mail the materials, with the patient's PIC and name, to:

**Quality Utilization Section - Dental
PO Box 45506
Olympia, WA 98504-5506**

Remember to include the authorization number on the ADA claim form whenever authorization has been obtained.

Orthodontic Information Sheet

State-Unique Procedure Code	Description	Prior Auth?	Maximum Allowable 0-18 yrs 19 yrs & up
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Orthodontic

Clinical Evaluations

0803D*	Orthodontic consultation Billable only by an orthodontist. This visit involves a referral from a client's general dentist to an orthodontic specialist.	No	\$34.00	Not Covered
0804D*	Orthodontic information (initial workup) Includes orthodontic oral examination, taking and processing clinical photographs, completing required form(s) and obtaining MAA's authorization decision.	No	\$40.00	Not Covered
	0805D has been replaced by 0806D and 0807D.			
0806D*	Orthodontic Case Study for cleft palate and craniofacial anomaly cases. Billable only by the treating orthodontic provider. Includes preparation of comprehensive diagnostic records (additional photos, study casts, cephalometric examination), formation of diagnosis and treatment plan from such records, and formal case conference. <u>Prior Authorization</u> <ul style="list-style-type: none"> • Prior authorization is required, if treating provider is not a member of a recognized craniofacial team. • Prior authorization is not required, if treating provider is a member of a recognized craniofacial team. 	See Descrp	\$180.00	Not Covered
0807D*	Orthodontic Case Study for severe malocclusion cases Billable only by the treating orthodontic provider. Includes preparation of comprehensive diagnostic records (additional photos, study casts, cephalometric examination), formation of diagnosis and treatment plan from such records, and formal case conference.	Yes	\$180.00	Not Covered

* Not an ADA CDT Code

State-Unique Procedure Code	Description	Prior Auth?	Maximum Allowable	
			0-18 yrs	19 yrs & up

Interceptive Orthodontics

0836D*	Interceptive orthodontic treatment for cleft palate and craniofacial anomaly cases. Payable only once per client. The maximum allowance includes all professional fees, laboratory costs, and required follow-up. No allowance for lost or broken appliance.	No	\$425.00	Not Covered
0837D*	Interceptive orthodontic treatment for severe malocclusion cases. Payable only once per client. The maximum allowance includes all professional fees, laboratory costs, and required follow-up. No allowance for lost or broken appliance.	Yes	\$315.00	Not Covered

* Not an ADA CDT Code

State-Unique Procedure Code	Description	Prior Auth?	Maximum Allowable	
			0-18 yrs	19 yrs & up

Limited Transitional Orthodontic Treatment

0840D*	Initial placement of appliance(s) for cleft palate and craniofacial anomaly cases. Includes first 3 months of treatment and appliance(s).	No	\$575.00	Not Covered
0841D*	Initial placement of appliance(s) for severe malocclusion cases. Includes first 3 months of treatment and appliance(s).	Yes	\$390.00	Not Covered
	0842D has been replaced by 0843D and 0844D.			
<p>For the following two codes (0843D and 0844D) to be billed:</p> <ul style="list-style-type: none"> • The provider must examine the client in the provider's office at least once during the 3-month period. • Services must be billed at the end of the 3-month period. For billing purposes, use a date towards the end of the 3-month period as the date of service. • Services billed using earlier dates in the 3-month period may be denied payment. • Actual service dates must be documented in the client's record. 				
0843D*	Each additional 3 months of limited transitional orthodontic treatment for cleft palate and craniofacial anomaly cases. Maximum of 3 units allowed.	No	\$170.00	Not Covered
0844D*	Each additional 3 months of limited transitional orthodontic treatment for severe malocclusion cases. Maximum of 3 units allowed.	Yes	\$170.00	Not Covered

* Not an ADA CDT Code

State-Unique Procedure Code	Description	Prior Auth?	Maximum Allowable 0-18 yrs 19 yrs & up
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Full Orthodontic Treatments

0866D*	<p>Initial placement of appliance(s) for a client with a cleft or craniofacial anomaly who <u>HAS HAD</u> limited transitional orthodontic treatment. Includes first 6 months of treatment and appliance(s).</p> <p style="text-align: center;"><u>Prior Authorization</u></p> <ul style="list-style-type: none"> • Prior authorization is required, if treating provider is not a member of a recognized craniofacial team. • Prior authorization is not required, if treating provider is a member of a recognized craniofacial team. 	See Descrp	\$1,250.00	Not Covered
0867D*	<p>Each additional 3 months of full orthodontic treatment for a client with a cleft or craniofacial anomaly who <u>HAS HAD</u> limited transitional treatment. Maximum of 6 units allowed.</p> <p>For this service:</p> <ul style="list-style-type: none"> • The provider must examine the client in the provider's office at least once during the 3-month period. • Services must be billed at the end of the 3-month period. For billing purposes, use a date towards the end of the 3-month period as the date of service. • Services billed using earlier dates in the 3-month period may be denied payment. • Actual service dates must be documented in the client's record. <p>Prior Authorization</p> <ul style="list-style-type: none"> • Prior authorization is required, if treating provider is not a member of a recognized craniofacial team. • Prior authorization is not required, if treating provider is a member of a recognized craniofacial team. 	See Descrp	\$240.00	Not Covered

* Not an ADA CDT Code

Dental Program

State-Unique Procedure Code	Description	Prior Auth?	Maximum Allowable 0-18 yrs 19 yrs & up	
0868D*	<p>Initial placement of appliance(s) for a client with a cleft or craniofacial anomaly who <u>HAS NOT</u> previously received limited transitional orthodontic treatment. Includes first 6 months of treatment and appliances.</p> <p style="text-align: center;"><u>Prior Authorization</u></p> <ul style="list-style-type: none"> • Prior authorization is required, if treating provider is not a member of a recognized craniofacial team. • Prior authorization is not required, if treating provider is a member of a recognized craniofacial team. 	See Descrp	\$1,300.00	Not Covered
0869D*	<p>Each additional 3 months of full orthodontic treatment for a cleft or craniofacial anomaly client who <u>HAS NOT</u> previously received limited transitional treatment. Maximum of 6 units allowed. Two additional units may be allowed with prior authorization.</p> <p>For this service:</p> <ul style="list-style-type: none"> • The provider must examine the client in the provider's office at least once during the 3-month period. • Services must be billed at the end of the 3-month period. For billing purposes, use a date towards the end of the 3-month period as the date of service. • Services billed using earlier dates in the 3-month period may be denied payment. • Actual service dates must be documented in the client's record. <p>Prior Authorization</p> <ul style="list-style-type: none"> • Prior authorization is required, if treating provider is not a member of a recognized craniofacial team. • Prior authorization is not required, if treating provider is a member of a recognized craniofacial team. 	See Descrp	\$350.00	Not Covered

* Not an ADA CDT Code

Dental Program

State-Unique Procedure Code	Description	Prior Auth?	Maximum Allowable 0-18 yrs 19 yrs & up	
0870D*	Initial placement of appliance(s) for a client with severe malocclusion, who <u>HAS HAD</u> limited transitional orthodontic treatment. Includes first 6 months of treatment and appliance(s).	Yes	\$950.00	Not Covered
0871D*	<p>Each additional 3 months of full orthodontic treatment for a client with severe malocclusion, who <u>HAS HAD</u> limited transitional treatment. Maximum of 6 units allowed.</p> <p>For this service:</p> <ul style="list-style-type: none"> • The provider must examine the client in the provider's office at least once during the 3-month period. • Services must be billed at the end of the 3-month period. For billing purposes, use a date towards the end of the 3-month period as the date of service. • Services billed using earlier dates in the 3-month period may be denied payment. • Actual service dates must be documented in the client's record. 	Yes	\$117.00	Not Covered

* Not an ADA CDT Code

Dental Program

State-Unique Procedure Code	Description	Prior Auth?	Maximum Allowable 0-18 yrs 19 yrs & up	
0872D*	Initial placement of appliance(s) for a client with severe malocclusion, who <u>HAS NOT</u> previously received limited transitional orthodontic treatment. Includes first 6 months of treatment and appliance(s).	Yes	\$1,030.00	Not Covered
0873D*	Each additional 3 months of full orthodontic treatment for a client with severe malocclusion, who <u>HAS NOT</u> previously received limited transitional treatment. Maximum of 6 units allowed. Two additional units may be allowed with prior authorization. For this service: <ul style="list-style-type: none">• The provider must examine the client in the provider's office at least once during the 3-month period.• Services must be billed at the end of the 3-month period. For billing purposes, use a date towards the end of the 3-month period as the date of service.• Services billed using earlier dates in the 3-month period may be denied payment.• Actual service dates must be documented in the client's record.	Yes	\$210.00	Not Covered

* Not an ADA CDT Code

Dental Program

State-Unique Procedure Code	Description	Prior Auth?	Maximum Allowable	
			0-18 yrs	19 yrs & up
0874D*	Brace removal and provision of permanent retainer , for a client whose appliance was placed by an orthodontic provider not participating with MAA, and/or whose treatment was previously covered by another third-party payor. Fee includes debanding and removal of cement.	Yes	\$100.00	Not Covered
0875D*	Each three-month period of follow-up orthodontic care for a client who meets the criteria in WAC 388-535-1250, but whose banding, appliance placement and/or initial follow-up care was done by a provider not participating with MAA, or whose treatment was authorized and previously covered by another third-party payor. This follow-up care is for a period not to exceed one year, or the length of time remaining under the treatment plan authorized by the previous payor, whichever is shorter. One unit allowed every 3 months, up to a total of 4 units.	Yes	\$120.00	Not Covered

* Not an ADA CDT Code

Billing for Evaluation and Management Procedure Codes

Effective with dates of service on or after July 1, 2000, orthodontists may bill the following Evaluation and Management (E&M) procedure codes using the criteria listed below:

- Only one orthodontic provider, participating as an active member of the craniofacial team, may bill for any one of these E&M procedure codes per client, per visit.
- **E&M procedure codes must be billed on the American Dental Association (ADA) claim form and cannot be billed in combination with periodic/limited/comprehensive oral evaluations.** The qualifying diagnosis code(s) (see list on page K23) must be kept in the client's record.

Evaluation and Management Codes Billable Only by Orthodontists On MAA-Recognized Craniofacial Teams			
CPT Procedure Code	Description	NFS	FS
99201	See your CPT manual for description.	\$39.84	\$22.97
99202	See your CPT manual for description.	\$61.73	\$42.71
99203	See your CPT manual for description.	\$86.49	\$63.53
99204	See your CPT manual for description.	\$124.90	\$94.39

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To obtain a hard copy, call 1-800-562-6188.**

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CPT Procedure Code	Description	NFS	FS
99205	See your CPT manual for description.	\$155.04	\$123.10
99211	See your CPT manual for description.	\$19.74	\$9.69
99212	See your CPT manual for description.	\$33.38	\$22.25

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CPT Procedure Code	Description	NFS	FS
99213	See your CPT manual for description.	\$45.94	\$32.30
99214	See your CPT manual for description.	\$71.06	\$52.04

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CPT Procedure Code	Description	NFS	FS
99215	See your CPT manual for description.	\$105.52	\$83.62
99241	See your CPT manual for description.	\$33.78	\$21.48

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CPT Procedure Code	Description	NFS	FS
99242	See your CPT manual for description.	\$55.48	\$40.04
99243	See your CPT manual for description.	\$70.69	\$52.79
99244	See your CPT manual for description.	\$97.98	\$76.95

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CPT Procedure Code	Description	NFS	FS
99245	See your CPT manual for description.	\$127.29	\$102.68

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Related Diagnosis Codes on next page ➞

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Related Diagnosis Codes

The E&M procedure codes listed on pages K16 through K22 may be billed only for clients with any of the diagnosis codes listed on this page. The qualifying diagnosis code(s) must be kept in the client's record:

Dx Code	Description
213.1	Benign neoplasm of lower jaw bone
744.9	Unspecified anomalies of face and neck
749.0	Cleft palate
749.00	Cleft palate, unspecified
749.01	Unilateral, complete
749.02	Unilateral, incomplete (cleft uvula)
749.03	Bilateral, complete
749.04	Bilateral, incomplete
749.10	Cleft lip, unspecified
749.11	Unilateral, complete
749.12	Unilateral, incomplete
749.13	Bilateral, complete
749.14	Bilateral, incomplete
749.2	Cleft palate with cleft lip
749.20	Cleft palate with cleft lip, unspecified
749.21	Unilateral, complete
749.22	Unilateral, incomplete
749.23	Bilateral, complete
749.24	Bilateral, incomplete
749.25	Other combinations
754.0	Certain congenital musculoskeletal deformities of skull, face and jaw
755.55	Acrocephalosyndactyly
756.0	Anomalies of skull and face bones
802.2	Mandible, closed
802.21	Condylar process
802.22	Subcondylar
802.23	Coronoid process
802.24	Ramus, unspecified
802.25	Angle of jaw

Dx Code	Description
802.26	Symphysis of body
802.27	Alveolar border of body
802.28	Body, other and unspecified
802.29	Multiple sites
802.3	Mandible, open
802.31	Condylar process
802.32	Subcondylar
802.33	Coronoid process
802.34	Ramus, unspecified
802.35	Angle of jaw
802.36	Symphysis of body
802.37	Alveolar border of body
802.38	Body, other and unspecified
802.39	Multiple sites
802.4	Malar and maxillary bones, closed
802.5	Malar and maxillary bones, open
802.6	Orbital floor(blow-out), closed

ADA Procedure Code	Description	Prior Auth?	Maximum Allowable	
			0-18 yrs	19 yrs & up

Adjunctive General Services

Unclassified Treatment

09110	Palliative (emergency) treatment of dental pain – minor procedures (e.g., open and drain abscess). Open and drain is included in the fee for root canal when performed during the same sitting. Tooth or quadrant designation required.	No	\$45.00	\$45.00
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Anesthesia

- To bill general anesthesia, intravenous sedation, and other drugs, the provider must:
 - ✓ Be an Oral Surgeon; or
 - ✓ Have a current Conscious Sedation Permit from the Department of Health (DOH); and
 - ✓ Submit proof of Conscious Sedation certification to the Provider Enrollment Unit (see Important Contacts for address) before delivering first service to MAA client.
- MAA pays for general anesthesia administered by an anesthesiologist or Certified Registered Nurse Anesthetist (CRNA). Anesthesiologists and CRNAs may bill using the MAA Resource Based Relative Value Scale (RBRVS) Fee Schedule (call Provider Inquiry & Relations at 1-800-562-6188 to obtain a copy).
- For each patient, the provider must:
 - ✓ Perform a pre-anesthetic examination and evaluation;
 - ✓ Prescribe the anesthesia plan;
 - ✓ Personally participate in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence;
 - ✓ Ensure that any procedures in the anesthesia plan that he or she does not perform, are performed by a qualified individual as defined in program operating instructions;
 - ✓ Monitor the course of anesthesia administration at frequent intervals;
 - ✓ Remain physically present and available for immediate diagnosis and treatment of emergencies; and
 - ✓ Provide indicated post anesthesia care.
- When billing for general anesthesia, show the actual beginning and ending times on your claim form. State the total number of minutes on the claim. Anesthesia time begins when the anesthesiologist or CRNA starts to physically prepare the patient for the induction of anesthesia in the operating room area (or its equivalent) and ends when the anesthesiologist or CRNA is no longer in constant attendance (i.e., when the patient can be safely placed under post-operative supervision.)

ADA Procedure Code	Description	Prior Auth?	Maximum Allowable 0-18 yrs 19 yrs & up
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- When general anesthesia is administered by:
 - ✓ The attending dentist, payment will be made at the rate of 50% of the maximum allowable.
 - ✓ A provider other than the attending dentist, maximum allowance is paid.
- The name of the provider who administered the anesthesia must be in the Remarks field (field 38) of the claim form, if that provider is different from the billing provider.
- MAA calculates payment according to the formula below for general anesthesia administered by a dentist:

\$75.50 + [TIME UNITS X \$15.10] = MAXIMUM ALLOWABLE FEE
Note: Every 15 minute increment, or fraction, equals 1 time unit.

- Bill for pharmaceuticals using the appropriate code(s) below. If you are billing electronically, attach an itemized list of pharmaceuticals to the claim form. Send this information to MAA as backup documentation for electronically billed claims for any charges exceeding \$45.00 (see Important Contacts).

09220	General anesthesia Requires justification (e.g., client mentally impaired, difficult surgery, fractures for children). General anesthesia administered by the operating dentist may be reported by using this code and showing actual anesthetic administration time.	No	By Report	By Report
0923D*	Oral sedation administration Administration allowance for children 13 years of age and under or DDD clients.	No	\$14.00 Ages 0-13	\$14.00 DDD clients only
09240	Intravenous sedation administration	No	\$32.32	\$31.53
09630	Other drugs and/or medicaments Bill pharmaceuticals using this procedure code. Payable only when billed with either 09220, 0923D, or 09240.	No	By Report	By Report

* Not an ADA CDT Code

ADA Procedure Code	Description	Prior Auth?	Maximum Allowable	
			0-18 yrs	19 yrs & up

Professional Visits

09410	Bedside call, nursing facility or residence at the request of the physician. This code may be billed only once per day.	No	\$32.32	\$31.53
<ul style="list-style-type: none"> No additional payment will be made for multiple calls for patients in nursing facility settings, or for multiple facilities. Procedures including evaluations or assessments must be billed with the appropriate procedure codes. A referral for dental care must be documented in the client's record. This referral may be initiated by the client's attending physician, facility nursing supervisor or client's legal guardian when a dental problem is identified. The client or guardian has freedom of choice of dentist in the community. The on-staff dental provider may be called when the patient has no preference and concurs with the request. Medicaid-eligible clients in nursing facilities may not be billed for services that exceed those covered under this program. Services outside this program should be arranged by the nursing facility and may be covered under their rate structure. 				
09420	Hospital calls (includes emergency care) Maximum of one call per day. Not covered for routine preoperative and postoperative visits.	No	\$32.32	\$31.53

Drugs

09610	Therapeutic drug injection. Antibiotics only. Includes cost of drug.	No	\$11.11	\$10.51
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ADA Procedure Code	Description	Prior Auth?	Maximum Allowable	
			0-18 yrs	19 yrs & up

Miscellaneous Services

09920	Class I behavior management A Class I case involves a patient whose documented behavior requires the assistance of one additional dental professional staff to protect the patient from self-injury while treatment is rendered. Use of nitrous oxide is included in allowance.	No	\$6.18	\$6.30
0998D*	Class II behavior management A Class II behavior management case requires documented assistance of more than one additional dental professional staff and the use of advanced behavior techniques to protect the patient from self-injury while treatment is rendered. Use of nitrous oxide is included in allowance.	No	\$25.25	\$25.76 DDD clients only
09951	Occlusal adjustment, limited Allowed once every 12 months – per quadrant. Quadrant designation required.	No	\$14.14 (13-18 yrs only)	\$13.66

* Not an ADA CDT Code

Oral Surgery

Hospital

1. Short Stay/Outpatient

- Medically necessary dental-related hospital short stays do not require authorization. Documentation must be maintained in the client's file.
- Preadmission History and Physical Information for Healthy Options clients receiving outpatient hospital treatment:
 - ✓ Clients enrolled in a managed health care plan may have a History and Physical (H&P) done for a dental hospital admission by any provider with admitting privileges to the hospital where the dental treatment will be provided.
 - ✓ Physician claims for H&Ps are to be billed to MAA as fee-for-service and require the appropriate ICD-9-CM dental diagnosis code on the HCFA-1500 claim form. State that the procedure is an H&P for dental admission to a short stay unit. Billers must put this in the *Remarks/Comments* field.

2. Inpatient

Nonemergent oral surgeries performed in an inpatient setting are generally a noncovered service. Exceptions to this policy are evaluated for DDD clients and children 18 years of age and under, whose surgery cannot be performed in an office setting, e.g., orthognathic cleft palate bone grafting. Exceptions require prior written authorization for the inpatient hospitalization.

Assistant Surgeon

Assistant surgeons will be reimbursed at 20 percent of the maximum allowance for those procedures indicating “Yes” in the *Assistant Surgeon Allowed* column of the fee schedule. State in the description of service area on the claim form (field 37) if assistant at surgery.

Oral Surgery

- A. Global surgery reimbursement includes the provision of the following services:
- The operation;
 - Preoperative visits, in or out of the hospital, beginning on the day prior to surgery;
 - Services by the primary surgeon, in or out of the hospital, during a standard 90-day postoperative period (0 to 10 days for minor surgery);
 - Dressing changes; local incisional care and removal of operative packs; removal of cutaneous sutures, staples, lines, wires, tubes, drains and splints; and
 - All additional medical or surgical services required.
- B. When surgical procedure(s) are carried out within the listed period for follow-up care of a previous surgery, the follow-up periods will continue concurrently to their normal terminations.
- C. When multiple surgical procedures are performed on the same client and at the same operative session, total payment equals the sum of 100% of the global fee for the highest value procedure. Reimbursement for the second through the fifth surgical procedures will be 50% of the global fee.

To expedite payment of your claim, bill all the surgeries for the same operative session on the same claim form. Use the American Dental Association claim form, not the HCFA – 1500.

POSTOPERATIVE VISITS ARE INCLUDED IN THE SURGICAL FEE.

CPT™ Procedure Code	Description	Follow-up Days	Assistant Surgeon Allowed?	Maximum Allowable (All Ages)
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Oral Surgery – Oral Surgeons Integumentary System

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Excision – Debridement

NFS

FS

11044	See your CPT manual for description.	10	No	142.27	127.51
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Biopsy

11100	See your CPT manual for description.	Zero	No	42.06	25.95
11101	See your CPT manual for description.	Zero	No	20.80	13.42

Excision - Benign Lesions

11440	See your CPT manual for description.	10	No	63.53	41.38
11441	See your CPT manual for description.	10	No	77.40	55.25
11442	See your CPT manual for description.	10	No	87.69	64.43
11443	See your CPT manual for description.	10	No	111.40	84.33
11444	See your CPT manual for description.	10	No	138.47	110.73
11446	See your CPT manual for description.	10	No	172.47	143.62

Excision – Malignant Lesions

11640	See your CPT manual for description.	10	No	84.78	58.61
11641	See your CPT manual for description.	10	No	114.76	87.02
11642	See your CPT manual for description.	10	No	131.09	104.02
11643	See your CPT manual for description.	10	No	153.68	123.71

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CPT™ Procedure Code	Description	Follow-up Days	Assistant Surgeon Allowed?	Maximum Allowable (All Ages)
11644	See your CPT manual for description.	10	No	191.26
11646	See your CPT manual for description.	10	No	247.86

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Dental Program

CPT™ Procedure Code	Description	Follow-up Days	Assistant Surgeon Allowed?	Maximum Allowable (All Ages)
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Repair – Simple

NFS FS

12001	See your CPT manual for description.	10	No	72.93	56.37
12002	See your CPT manual for description.	10	No	80.08	63.31
12004	See your CPT manual for description.	10	No	95.52	77.85
12005	See your CPT manual for description.	10	No	118.56	99.55
12011	See your CPT manual for description.	10	No	77.62	59.95
12013	See your CPT manual for description.	10	No	87.91	69.57
12014	See your CPT manual for description.	10	No	104.24	84.56
12015	See your CPT manual for description.	10	No	131.54	109.39
12016	See your CPT manual for description.	10	No	159.50	138.25

Repair – Intermediate

12031	See your CPT manual for description.	10	No	89.03	67.56
12032	See your CPT manual for description.	10	No	101.34	77.62
12034	See your CPT manual for description.	10	No	120.57	102.68
12035	See your CPT manual for description.	10	No	138.69	123.04
12051	See your CPT manual for description.	10	No	102.68	78.97
12052	See your CPT manual for description.	10	No	115.21	88.14
12053	See your CPT manual for description.	10	No	128.63	110.96
12054	See your CPT manual for description.	10	No	151.00	131.09
12055	See your CPT manual for description.	10	No	190.59	168.22

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CPT™ Procedure Code	Description	Follow-up Days	Assistant Surgeon Allowed?	Maximum Allowable (All Ages)
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Repair – Complex

NFS

FS

13131	See your CPT manual for description.	10	No	153.01	124.60
13132	See your CPT manual for description.	10	No	243.83	200.66
13133	See your CPT manual for description.	90	No	77.18	73.37
13150	See your CPT manual for description.	10	No	164.87	138.92
13151	See your CPT manual for description.	10	No	188.58	151.00
13152	See your CPT manual for description.	10	No	272.91	221.24
13153	See your CPT manual for description.	Zero	No	84.78	79.86
13160	See your CPT manual for description.	90	No	361.05	361.05

Adjacent Tissue Transfer or Rearrangement

14040	See your CPT manual for description.	90	No	353.22	287.90
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Free Skin Grafts

15120	See your CPT manual for description.	90	No	395.05	379.17
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CPT™ Procedure Code	Description	Follow-up Days	Assistant Surgeon Allowed?	Maximum Allowable (All Ages)
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Musculoskeletal System

General

Excision				NFS	FS
20220	See your CPT manual for description.	Zero	No	85.45	66.66
Introduction or Removal					
20520	See your CPT manual for description.	10	No	103.13	80.31
20605	See your CPT manual for description.	Zero	No	38.03	21.70
20670	See your CPT manual for description.	10	No	104.24	80.76
20680	See your CPT manual for description.	90	No	167.10	167.10

Grafts

20902	See your CPT manual for description.	90	Yes	329.51	329.51
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Head

Incision

21010	See your CPT manual for description.	90	No	431.07	431.07
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Excision

21025	See your CPT manual for description.	90	No	363.74	331.75
21030	See your CPT manual for description.	90	No	248.98	219.67
21031	See your CPT manual for description.	90	No	156.37	120.80
21032	See your CPT manual for description.	90	No	158.60	123.48
21034	See your CPT manual for description.	90	Yes	570.21	570.21

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Dental Program

CPT™ Procedure Code	Description	Follow-up Days	Assistant Surgeon Allowed?	Maximum Allowable (All Ages)
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NFS FS

21040	See your CPT manual for description.	90	No	114.76	84.78
21041	See your CPT manual for description.	90	No	286.56	238.69
21044	See your CPT manual for description.	90	Yes	480.28	480.28
21045	See your CPT manual for description.	90	Yes	659.24	659.24
21050	See your CPT manual for description.	90	No	517.42	517.42
21060	See your CPT manual for description.	90	Yes	489.68	489.68
21070	See your CPT manual for description.	90	No	340.47	340.47

Introduction or Removal

21076	See your CPT manual for description.	10	No	600.41	483.42
21077	See your CPT manual for description.	90	No	1,511.09	1,216.93
21081	See your CPT manual for description.	90	No	1,077.56	851.40
21100	See your CPT manual for description.	90	No	161.96	153.68
21110	See your CPT manual for description.	90	No	244.95	197.75
21120	See your CPT manual for description.	90	No	258.60	216.09

Repair, Revision or Reconstruction

21141	See your CPT manual for description.	90	Yes	721.43	721.43
21142	See your CPT manual for description.	90	Yes	764.61	764.61
21143	See your CPT manual for description.	90	Yes	759.24	759.24

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					NFS FS
21145	See your CPT manual for description.	90	Yes	758.79	758.79
21146	See your CPT manual for description.	90	Yes	786.98	786.98
21147	See your CPT manual for description.	90	Yes	822.54	822.54
21150	See your CPT manual for description.	90	Yes	959.67	959.67
21151	See your CPT manual for description.	90	Yes	1,129.68	1,129.68
21154	See your CPT manual for description.	90	Yes	1,180.46	1,180.46
21155	See your CPT manual for description.	90	Yes	1,318.04	1,318.04
21159	See your CPT manual for description.	90	Yes	1,652.92	1,652.92
21160	See your CPT manual for description.	90	Yes	1,754.26	1,754.26

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				NFS	FS
21193	See your CPT manual for description.	90	Yes	666.85	666.85
21194	See your CPT manual for description.	90	Yes	771.32	771.32
21195	See your CPT manual for description.	90	Yes	682.51	682.51
21196	See your CPT manual for description.	90	Yes	749.17	749.17
21198	See your CPT manual for description.	90	Yes	638.22	638.22
21206	See your CPT manual for description.	90	Yes	558.13	558.13
21208	See your CPT manual for description.	90	No	476.48	462.84
21209	See your CPT manual for description.	90	Yes	289.24	271.35
21210	See your CPT manual for description.	90	No	468.43	391.25
21215	See your CPT manual for description.	90	No	488.34	396.17
21230	See your CPT manual for description.	90	No	479.84	479.84
21240	See your CPT manual for description.	90	Yes	644.48	644.48
21242	See your CPT manual for description.	90	Yes	607.12	607.12
21243	See your CPT manual for description.	90	Yes	814.94	814.94

Fracture and/or Dislocation

21300	See your CPT manual for description.	Zero	No	56.37	30.20
21310	See your CPT manual for description.	Zero	No	49.21	23.49

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				NFS	FS
21315	See your CPT manual for description.	10	No	91.27	68.68
21320	See your CPT manual for description.	10	No	118.78	89.03
21325	See your CPT manual for description.	90	No	175.38	175.38
21330	See your CPT manual for description.	90	No	253.68	253.68
21335	See your CPT manual for description.	90	No	392.82	392.82
21336	See your CPT manual for description.	90	No	240.03	240.03
21337	See your CPT manual for description.	90	No	151.22	129.30
21338	See your CPT manual for description.	90	No	276.27	276.27
21339	See your CPT manual for description.	90	Yes	346.29	346.29
21340	See your CPT manual for description.	90	No	456.57	456.57
21343	See your CPT manual for description.	90	Yes	522.34	522.34
21344	See your CPT manual for description.	90	Yes	724.56	724.56
21345	See your CPT manual for description.	90	No	371.34	366.42
21346	See your CPT manual for description.	90	No	460.60	460.60
21347	See your CPT manual for description.	90	Yes	525.47	525.47
21348	See your CPT manual for description.	90	Yes	644.03	644.03

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CPT™ Procedure Code	Description	Follow-up Days	Assistant Surgeon Allowed?	Maximum Allowable (All Ages)	
				NFS	FS
21355	See your CPT manual for description.	10	No	147.87	130.64
21356	See your CPT manual for description.	10	No	187.01	187.01
21360	See your CPT manual for description.	90	Yes	296.85	296.85
21365	See your CPT manual for description.	90	Yes	621.21	621.21
21366	See your CPT manual for description.	90	Yes	694.36	694.36
21385	See your CPT manual for description.	90	Yes	407.81	407.81
21386	See your CPT manual for description.	90	Yes	408.25	408.25
21387	See your CPT manual for description.	90	Yes	405.34	405.34
21390	See your CPT manual for description.	90	Yes	463.51	463.51
21395	See your CPT manual for description.	90	Yes	519.66	519.66
21400	See your CPT manual for description.	90	No	86.12	62.64
21401	See your CPT manual for description.	90	Yes	157.71	139.14
21406	See your CPT manual for description.	90	Yes	294.17	294.17
21407	See your CPT manual for description.	90	Yes	369.78	369.78
21408	See your CPT manual for description.	90	Yes	503.77	503.77

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CPT™ Procedure Code	Description	Follow-up Days	Assistant Surgeon Allowed?	Maximum Allowable (All Ages)	
				NFS	FS
21421	See your CPT manual for description.	90	No	266.43	248.08
21422	See your CPT manual for description.	90	Yes	382.75	382.75
21423	See your CPT manual for description.	90	Yes	446.95	446.95
21431	See your CPT manual for description.	90	Yes	300.65	300.65
21432	See your CPT manual for description.	90	Yes	372.46	372.46
21433	See your CPT manual for description.	90	Yes	992.56	992.56
21435	See your CPT manual for description.	90	Yes	704.66	704.66
21436	See your CPT manual for description.	90	Yes	1,025.44	1,025.44
21440	See your CPT manual for description.	90	No	155.47	134.44
21445	See your CPT manual for description.	90	Yes	268.89	250.10
				NFS	FS
21450	See your CPT manual for description.	90	No	164.20	131.54
21451	See your CPT manual for description.	90	No	251.22	233.99
21452	See your CPT manual for description.	90	No	144.96	104.47

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CPT™ Procedure Code	Description	Follow-up Days	Assistant Surgeon Allowed?	Maximum Allowable (All Ages)
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				NFS	FS
21453	See your CPT manual for description.	90	No	284.10	265.53
21454	See your CPT manual for description.	90	No	293.72	293.72
21461	See your CPT manual for description.	90	Yes	387.22	377.83
21462	See your CPT manual for description.	90	Yes	459.93	443.82
21465	See your CPT manual for description.	90	Yes	462.84	462.84
21470	See your CPT manual for description.	90	Yes	669.09	669.09
21480	See your CPT manual for description.	Zero	No	41.38	24.61
21485	See your CPT manual for description.	90	No	159.72	140.26
21490	See your CPT manual for description.	90	Yes	433.75	433.75
21493	See your CPT manual for description.	90	No	53.91	52.57
21494	See your CPT manual for description.	90	Yes	266.20	266.20
21495	See your CPT manual for description.	90	Yes	251.44	251.44
21497	See your CPT manual for description.	90	No	187.46	177.84

Neck (Soft Tissues) and Thorax

Excision					
21550	See your CPT manual for description.	10	No	82.99	66.44

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Endoscopy/Arthroscopy

NFS

FS

29800	See your CPT manual for description.	90	No	283.20	283.20
29804	See your CPT manual for description.	90	Yes	394.16	394.16

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CPT™ Procedure Code	Description	Follow-up Days	Assistant Surgeon Allowed?	Maximum Allowable (All Ages)
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Respiratory System

Nose – Repair

NFS

FS

30580	See your CPT manual for description.	90	No	284.77	246.52
30600	See your CPT manual for description.	90	No	233.54	233.54

Accessory Sinuses – Incision

31000	See your CPT manual for description.	10	No	54.58	36.91
31030	See your CPT manual for description.	90	No	267.32	267.32

Trachea – Incision

31603	See your CPT manual for description.	Zero	No	171.80	171.80
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CPT™ Procedure Code	Description	Follow-up Days	Assistant Surgeon Allowed?	Maximum Allowable (All Ages)	
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Digestive System

Vestibule of Mouth

NFS FS

Incision

40800	See your CPT manual for description.	10	No	55.25	37.36
40801	See your CPT manual for description.	10	No	104.69	88.59
40806	See your CPT manual for description.	Zero	No	19.24	16.78

Excision, Destruction

40808	See your CPT manual for description.	10	No	51.23	46.31
40810	See your CPT manual for description.	10	No	71.14	59.50
40812	See your CPT manual for description.	10	No	101.56	91.05
40814	See your CPT manual for description.	90	No	160.62	140.71
40816	See your CPT manual for description.	90	No	169.34	149.66
40819	See your CPT manual for description.	90	No	106.93	97.76

Repair

40830	See your CPT manual for description.	10	No	73.82	73.82
40831	See your CPT manual for description.	10	No	106.93	106.93

Tongue, Floor of Mouth

Incision

41000	See your CPT manual for description.	10	No	61.74	49.66
41005	See your CPT manual for description.	10	No	57.49	51.67
41006	See your CPT manual for description.	90	No	128.18	121.69
41007	See your CPT manual for description.	90	No	142.94	138.69
41008	See your CPT manual for description.	90	No	126.39	118.56
41009	See your CPT manual for description.	90	No	160.62	155.70

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CPT™ Procedure Code	Description	Follow-up Days	Assistant Surgeon Allowed?	Maximum Allowable (All Ages)	
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NFS FS

41010	See your CPT manual for description.	10	No	59.50	59.50
41015	See your CPT manual for description.	90	No	144.73	136.46
41016	See your CPT manual for description.	90	No	179.63	174.49
41017	See your CPT manual for description.	90	No	154.13	146.97
41018	See your CPT manual for description.	90	No	213.19	205.58

Excision

41108	See your CPT manual for description.	10	No	56.60	50.33
41112	See your CPT manual for description.	90	No	128.40	113.86
41113	See your CPT manual for description.	90	No	151.67	130.64

Other Procedures

41520	See your CPT manual for description.	90	No	128.40	128.40
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Dentalalveolar Structures

Incision

41805	See your CPT manual for description.	10	No	58.16	57.94
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Excision

41822	See your CPT manual for description.	10	No	119.68	102.45
41823	See your CPT manual for description.	90	No	157.26	151.44
41825	See your CPT manual for description.	10	No	72.70	61.07
41826	See your CPT manual for description.	10	No	106.26	93.06
41827	See your CPT manual for description.	90	No	162.18	139.14

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				NFS	FS
41828	See your CPT manual for description.	10	No	153.46	145.85
41830	See your CPT manual for description.	10	No	155.70	152.12

Other Procedures

41874	See your CPT manual for description.	90	No	143.39	138.25
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Palate, Uvula

Excision

42106	See your CPT manual for description.	10	No	102.90	89.48
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Repair

42180	See your CPT manual for description.	10	No	111.85	107.15
42182	See your CPT manual for description.	10	No	163.08	163.08
42200	See your CPT manual for description.	90	Yes	474.02	474.02
42205	See your CPT manual for description.	90	Yes	433.53	433.53
42210	See your CPT manual for description.	90	Yes	589.00	589.00
42215	See your CPT manual for description.	90	Yes	384.99	384.99
42220	See your CPT manual for description.	90	Yes	294.39	294.39
42225	See your CPT manual for description.	90	Yes	403.33	403.33
42226	See your CPT manual for description.	90	Yes	426.15	426.15
42227	See your CPT manual for description.	90	Yes	382.08	382.08
42235	See your CPT manual for description.	90	Yes	316.54	316.54
42260	See your CPT manual for description.	90	Yes	352.33	352.33
42280	See your CPT manual for description.	10	No	74.72	68.45
42281	See your CPT manual for description.	10	No	80.31	74.27

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Salivary Gland and Ducts

NFS

FS

Incision

42330	See your CPT manual for description.	10	No	92.39	71.81
42335	See your CPT manual for description.	90	No	144.29	129.07

Excision

42408	See your CPT manual for description.	90	No	189.25	189.25
42440	See your CPT manual for description.	90	Yes	319.22	319.22
42450	See your CPT manual for description.	90	No	198.42	198.42

Repair

42500	See your CPT manual for description.	90	No	205.36	205.36
42505	See your CPT manual for description.	90	No	281.41	281.41

Other Procedures

42600	See your CPT manual for description.	90	No	224.15	214.75
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Nervous System

64600	See your CPT manual for description.	10	No	136.23	123.71
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CPT™ Procedure Code	Description	Follow-up Days	Assistant Surgeon Allowed?	Maximum Allowable (All Ages)
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Integumentary System

Skin, Subcutaneous

NFS

FS

Excision – Debridement

11044	See your CPT manual for description.	10	No	142.27	127.51
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Biopsy

11100	See your CPT manual for description.	Zero	No	42.06	25.95
11101	See your CPT manual for description.	Zero	No	20.80	13.42
11440	See your CPT manual for description.	10	No	63.53	41.38
11441	See your CPT manual for description.	10	No	77.40	55.25
11442	See your CPT manual for description.	10	No	87.69	64.43
11443	See your CPT manual for description.	10	No	111.40	84.33
11444	See your CPT manual for description.	10	No	138.47	110.73
11446	See your CPT manual for description.	10	No	172.47	143.62
11640	See your CPT manual for description.	10	No	84.78	58.61
11641	See your CPT manual for description.	10	No	114.76	87.02
11642	See your CPT manual for description.	10	No	131.09	104.02
11643	See your CPT manual for description.	10	No	153.68	123.71
11644	See your CPT manual for description.	10	No	191.26	157.04
11646	See your CPT manual for description.	10	No	247.86	229.96
12001	See your CPT manual for description.	10	No	72.93	56.37
12002	See your CPT manual for description.	10	No	80.08	63.31
12004	See your CPT manual for description.	10	No	95.52	77.85
12005	See your CPT manual for description.	10	No	118.56	99.55

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				NFS	FS
12011	See your CPT manual for description.	10	No	77.62	59.95
12013	See your CPT manual for description.	10	No	87.91	69.57
12015	See your CPT manual for description.	10	No	131.54	109.39
12016	See your CPT manual for description.	10	No	159.50	138.25

Repair – Intermediate

12031	See your CPT manual for description.	10	No	89.03	67.56
12032	See your CPT manual for description.	10	No	101.34	77.62
12034	See your CPT manual for description.	10	No	120.57	102.68
12035	See your CPT manual for description.	10	No	138.69	123.04
12051	See your CPT manual for description.	10	No	102.68	78.97
12052	See your CPT manual for description.	10	No	115.21	88.14
12053	See your CPT manual for description.	10	No	128.63	110.96
12054	See your CPT manual for description.	10	No	151.00	131.09
12055	See your CPT manual for description.	10	No	190.59	168.22

Repair – Complex

13131	See your CPT manual for description.	10	No	153.01	124.60
13132	See your CPT manual for description.	10	No	243.83	200.66
13133	See your CPT manual for description.	90	No	77.18	73.37
13150	See your CPT manual for description.	10	No	164.87	138.92
13151	See your CPT manual for description.	10	No	188.58	151.00
13152	See your CPT manual for description.	10	No	272.91	221.24
13153	See your CPT manual for description.	Zero	No	84.78	79.86
13160	See your CPT manual for description.	90	No	361.05	361.05

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NFS FS

Adjacent Tissue Transfer or Rearrangement

14040	See your CPT manual for description.	90	No	353.22	287.90
20220	See your CPT manual for description.	Zero	No	85.45	66.66
20520	See your CPT manual for description.	10	No	103.13	80.31
21030	See your CPT manual for description.	90	No	248.98	219.67
21031	See your CPT manual for description.	90	No	156.37	120.80
21032	See your CPT manual for description.	90	No	158.60	123.48
21034	See your CPT manual for description.	90	Yes	570.21	570.21
21040	See your CPT manual for description.	90	No	114.76	84.78
21041	See your CPT manual for description.	90	No	286.56	238.69
21044	See your CPT manual for description.	90	Yes	480.28	480.28
21045	See your CPT manual for description.	90	Yes	659.24	659.24

Introduction or Removal

21076	See your CPT manual for description.	10	No	600.41	483.42
21077	See your CPT manual for description.	90	No	1,511.09	1,216.93

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Repair, Revision or Reconstruction

NFS

FS

21141	See your CPT manual for description.	90	Yes	721.43	721.43
21142	See your CPT manual for description.	90	Yes	764.61	764.61
21143	See your CPT manual for description.	90	Yes	759.24	759.24

Fracture and/or Dislocation

21336	See your CPT manual for description.	90	No	240.03	240.03
21337	See your CPT manual for description.	90	No	151.22	129.30
21344	See your CPT manual for description.	90	Yes	724.56	724.56
21346	See your CPT manual for description.	90	No	460.60	460.60
21347	See your CPT manual for description.	90	Yes	525.47	525.47
21348	See your CPT manual for description.	90	Yes	644.03	644.03
21355	See your CPT manual for description.	10	No	147.87	130.64
21356	See your CPT manual for description.	10	No	187.01	187.01
21360	See your CPT manual for description.	90	Yes	296.85	296.85

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NFS FS

21365	See your CPT manual for description.	90	Yes	621.21	621.21
21366	See your CPT manual for description.	90	Yes	694.36	694.36
21385	See your CPT manual for description.	90	Yes	407.81	407.81
21406	See your CPT manual for description.	90	Yes	294.17	294.17
21407	See your CPT manual for description.	90	Yes	369.78	369.78
21408	See your CPT manual for description.	90	Yes	503.77	503.77
21421	See your CPT manual for description.	90	No	266.43	248.08
21422	See your CPT manual for description.	90	Yes	382.75	382.75
21423	See your CPT manual for description.	90	Yes	446.95	446.95
21436	See your CPT manual for description.	90	Yes	1,025.44	1,025.44
21445	See your CPT manual for description.	90	Yes	268.89	250.10
21453	See your CPT manual for description.	90	No	284.10	265.53

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CPT™ Procedure Code	Description	Follow-up Days	Assistant Surgeon Allowed?	Maximum Allowable (All Ages)	
				NFS	FS
21462	See your CPT manual for description.	90	Yes	459.93	443.82
21470	See your CPT manual for description.	90	Yes	669.09	669.09
21480	See your CPT manual for description.	Zero	No	41.38	24.61

Neck (Soft Tissues) and Thorax Excision

21550	See your CPT manual for description.	10	No	82.99	66.44
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CPT™ Procedure Code	Description	Follow-up Days	Assistant Surgeon Allowed?	Maximum Allowable (All Ages)
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Respiratory System

Nose – Repair

NFS FS

30580	See your CPT manual for description.	90	No	284.77	246.52
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CPT™ Procedure Code	Description	Follow-up Days	Assistant Surgeon Allowed?	Maximum Allowable (All Ages)	
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Digestive System

Vestibule of Mouth

NFS FS

Incision

40800	See your CPT manual for description.	10	No	55.25	37.36
40801	See your CPT manual for description.	10	No	104.69	88.59
40806	See your CPT manual for description.	Zero	No	19.24	16.78

Excision, Destruction

40808	See your CPT manual for description.	10	No	51.23	46.31
40819	See your CPT manual for description.	90	No	106.93	97.76

Repair

40831	See your CPT manual for description.	10	No	106.93	106.93
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CPT™ Procedure Code	Description	Follow-up Days	Assistant Surgeon Allowed?	Maximum Allowable (All Ages)
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Tongue and Floor of Mouth Incision

NFS FS

41000	See your CPT manual for description.	10	No	61.74	49.66
41005	See your CPT manual for description.	10	No	57.49	51.67
41006	See your CPT manual for description.	90	No	128.18	121.69
41007	See your CPT manual for description.	90	No	142.94	138.69
41008	See your CPT manual for description.	90	No	126.39	118.56
41009	See your CPT manual for description.	90	No	160.62	155.70
41010	See your CPT manual for description.	10	No	59.50	59.50
41015	See your CPT manual for description.	90	No	144.73	136.46
41016	See your CPT manual for description.	90	No	179.63	174.49
41017	See your CPT manual for description.	90	No	154.13	146.97
41018	See your CPT manual for description.	90	No	213.19	205.58

Excision

41108	See your CPT manual for description.	10	No	56.60	50.33
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Dentalalveolar Structures Excision

41825	See your CPT manual for description.	10	No	72.70	61.07
41827	See your CPT manual for description.	90	No	162.18	139.14
41830	See your CPT manual for description.	10	No	155.70	152.12

Other Procedures

41874	See your CPT manual for description.	90	No	143.39	138.25
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CPT™ Procedure Code	Description	Follow-up Days	Assistant Surgeon Allowed?	Maximum Allowable (All Ages)	
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Palate, Uvula
Excision

NFS FS

42106	See your CPT manual for description.	10	No	102.90	89.48
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Repair

42180	See your CPT manual for description.	10	No	111.85	107.15
42182	See your CPT manual for description.	10	No	163.08	163.08
42200	See your CPT manual for description.	90	Yes	474.02	474.02
42205	See your CPT manual for description.	90	Yes	433.53	433.53
42210	See your CPT manual for description.	90	Yes	589.00	589.00
42220	See your CPT manual for description.	90	Yes	294.39	294.39
42225	See your CPT manual for description.	90	Yes	403.33	403.33
42227	See your CPT manual for description.	90	Yes	382.08	382.08
42235	See your CPT manual for description.	90	Yes	316.54	316.54
42280	See your CPT manual for description.	10	No	74.72	68.45
42281	See your CPT manual for description.	10	No	80.31	74.27

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Emergency Medical/Dental State Only Programs

These state-only programs include the General Assistance Unemployable (GAU) program and the W program.

Who does this program apply to?

The schedule of procedures and fees in this section is to be used only when billing for services provided to GAU or W patients with the following conditions:

1. Apical abscess justified by clinical examination. The condition may be treated using one of the following methods:
 - a. Open and drain/palliative treatment; or
 - b. Extraction; or
 - c. Root canal.
2. Radiation therapy for cancer of the mouth only for a total dental extraction performed and because of that prior to radiation therapy;
3. Extractions in the treatment of fractures;
4. Oral fracture care;
5. Cyst treatment;
6. Tumor therapy; or
7. Sequestrectomies.

Billing Procedures

1. The major procedure and all ancillary services must be billed as one treatment plan. Ancillary services will not be considered separately.
2. MAA may require reports and/or X-rays to make an authorization determination. In your request for prior authorization, be sure to include a written justification in *field 61* of the ADA claim form. Remember to mark any X-rays you send with your name and provider number.

For detailed instructions on how to complete an **ADA claim form**, refer to the section on How to Fill Out the ADA Form (Section H).

3. Submit the original claim (*make sure the client's PIC is on the claim*), and any necessary authorization documentation. When MAA returns the original to you, look at the Dental Consultant section for the authorization number and any pertinent comments by the Dental Consultant.

Is prior authorization required?

- If the procedure code has “**Yes**” in the **Prior Authorization** column, you must obtain prior authorization from MAA.
- If the procedure code has “**No**” in the **Prior Authorization** column, you do not need to obtain prior authorization from MAA.

For clients, 18 years of age and older, who are eligible for either of these state only programs (GAU or W), certain dental conditions are considered to be medical in nature and are covered for treatment.

How do I obtain written prior authorization?

Send written requests for prior authorization to:

**Medical Assistance Administration
Quality Utilization Section - Dental
PO Box 45506
Olympia WA 98504-5506**

Where should I send my claim?

Send claims to:

Division of Program Support
PO Box 9253
Olympia, WA 98507-9253

Refer to the “Important Contacts” section at the front of this billing instruction for other addresses.

ADA Procedure Code	Description	Prior Auth?	Maximum Allowable	
			0-18 yrs	19 yrs & up

Diagnostic

Clinical Oral Evaluations

00140	Limited oral evaluation An evaluation or reevaluation limited to a specific oral health situation or problem. This code should be used to bill for an evaluation when the dentist is giving limited/emergent services for a specific problem or IS ONLY providing an evaluation for referral and IS NOT providing dental services for the individual. Typically, patients receiving this type of evaluation have been referred for a specific problem and/or present with dental emergencies, trauma, acute infections, etc.	No	\$20.00	\$20.00
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Clinical Oral Examinations

Not to be used for hospital calls for clients outside the GAU/W program. Use procedure code 09420 – Page J3.				
0002D*	Hospital calls – emergency care only	No	\$32.32	\$31.53

* Not an ADA CDT Code

ADA Procedure Code	Description	Prior Auth?	Maximum Allowable	
			0-18 yrs	19 yrs & up

Radiographs

00210	Intraoral – complete series (including bitewings) Complete series x-rays will be allowed only once in a 3-year period. A complete intraoral series consists of 14 periapicals and one series of 4 bitewings.	No	\$43.00	\$30.00
00220	Intraoral periapical – single, first film.	No	\$7.07	\$6.30
00230	Intraoral periapical – each additional film	No	\$2.02	\$1.05
00240	Intraoral – occlusal, film	No	\$8.08	\$6.30
00330	<p>Panoramic film – maxilla and mandible</p> <p>Allowable for oral surgical purposes only. Documentation must be entered in the client’s file.</p> <p>Panorex, panelipse or orthopantograph are also allowed under this code. Panoramic-type films are allowed once in a 3-year period.</p> <ol style="list-style-type: none"> A shorter interval between panoramic – type x-rays may be allowed for: <ol style="list-style-type: none"> Emergent services, with authorization from MAA within 72 hours of the service; or Oral surgical services, with written prior authorization from MAA. This 3-year time limitation does not apply to preoperative or postoperative surgery cases. <p>Doing <u>both</u> a panoramic film and an intraoral complete series is not allowed.</p>	No	\$43.00	\$22.07

ADA Procedure Code	Description	Prior Auth?	Maximum Allowable	
			0-18 yrs	19 yrs & up

Test and Laboratory Examination

00460	Pulp vitality test Allowed one time, per day with justification. Tooth designation required.	No	\$12.12	\$8.40
00501	Histopathologic examination Histological examination of oral hard/soft tissue.	No	\$42.42	\$40.98

ADA Procedure Code	Description	Prior Auth?	Maximum Allowable	
			0-18 yrs	19 yrs & up

Oral Surgery – Dentists

Includes Preoperative and Postoperative Treatment

The department covers medically necessary services provided in a hospital in connection with the care and treatment of teeth, jaws, or structure directly supporting the teeth, if the procedure requires hospitalization in connection with the provision of such services.

Services covered under this section must be furnished under the direction of a physician or a dentist. (WAC 388-556-0400)

Simple Extraction (includes local anesthesia and routine postoperative care)

07110	Single tooth (initial) Tooth designation required.	No	\$78.46	\$41.00
07120	Each additional tooth (same day) regardless of quadrant Tooth designation required.	No	\$24.24	\$25.22
07130	Root removal exposed roots Example: Patient with missing crown. Tooth designation required.	No	\$37.37	\$30.48

Surgical Extractions (includes local anesthesia and routine postoperative care)

07210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth prior to removal of tooth. Tooth designation required.	No	\$90.00	\$59.89
07220	Removal of impacted tooth-soft tissue Impaction that requires incisions of overlying soft tissue and the removal of the tooth. Tooth designation required.	No	\$90.90	\$76.71
07230	Removal of impacted tooth-partially bony Impaction that requires incisions of overlying soft tissue, elevation of a flap, removal of bone, and the removal of the tooth. Tooth designation required.	No	\$111.10	\$104.03
07240	Removal of impacted tooth-completely bony Impaction that requires incision of overlying soft tissue, elevation of a flap, removal of bone, and sectioning of the tooth for removal. Allowed only when pathology is present. Tooth designation required.	No	\$146.45	\$132.41

ADA Procedure Code	Description	Prior Auth?	Maximum Allowable	
			0-18 yrs	19 yrs & up
07241	Removal of impacted tooth-completely bony, with unusual surgical complications. Impaction that requires incision of overlying soft tissue, elevation of flap, removal of bone, sectioning of the tooth for removal, and/or presents unusual difficulties and circumstances. Allowed only when pathology is present. Tooth designation required.	No	\$191.90	\$140.81
07250	Root recovery (surgical removal of residual root) Tooth designation required.	No	\$80.80	\$48.34

ADA Procedure Code	Description	Prior Auth?	Maximum Allowable	
			0-18 yrs	19 yrs & up

Restorative

Root Canal Therapy (includes treatment plan, x-rays, clinical procedures and follow-up care)

<ul style="list-style-type: none"> • Separate charges are allowed for open and drain and for root canal treatments if the procedures are done on different days. • Not covered for primary teeth. 				
0018D*	Permanent restoration associated with endodontic treatment. Tooth designation required.	No	\$48.48	\$46.82
03310	Anterior (excluding final restoration) Tooth designation required. Not covered for primary teeth.	No	\$250.00	\$139.76
03320	Biscupid (excluding final restoration) Tooth designation required. Not covered for primary teeth.	No	\$252.50	\$194.40
03330	Molar (excluding final restoration) Tooth designation required. Not covered for primary teeth.	No	\$282.80	\$216.34

Apicoectomy/Periradicular Services

03410	Apicoectomy/periradicular surgery – anterior	No	\$156.55	\$136.61
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* Not an ADA CDT Code

Prosthodontics, Removable

Use the seating date to bill for dentures.

Exception

The impression date may be used as the service date for dentures, including partials, only when:

- Related dental services, including laboratory services, were provided during a client's eligible period; and
- The client is not eligible at the time of delivery.

Initial Placement of Complete Dentures

Upper and/or lower complete dentures placed after extraction of teeth do not require prior authorization.

Replacement of Complete or Partial Dentures

Prior authorization for replacement of complete or partial dentures is not required when:

- Client's existing dentures are no longer serviceable and cannot be relined, rebased, are lost or damaged beyond repair;
- Client has been able to wear dentures successfully; and
- The denture meets the criteria of dentally necessary.

Required Documentation for Complete and Partial Dentures

To justify replacement of complete or partial dentures:

1. Document the justification for replacement of dentures in the client's record; **and**
2. For partial dentures, chart the **missing teeth** on the claim form **and** in the client's record; **and**
3. In the "Remarks for Unusual Services" field on the ADA claim form, write the justification for replacement of complete or partial dentures; or
4. If billing electronically, enter the justification in the "Comments/Remarks" field.

Noncovered Services

The following related denture services are not covered:

- Provision of dentures for *cosmetic* purposes; and
- Extraction of *asymptomatic teeth*, unless their removal constitutes the most cost effective dental procedure for the provision of dentures.

Dentures, partial dentures and rebased dentures require labeling in accordance with state law.

ADA Procedure Code	Description	Prior Auth?	Maximum Allowable	
			0-18 yrs	19 yrs & up

Complete Dentures (including 6 months post-delivery care)

- Upper and/or lower complete dentures placed after extraction of teeth do not require prior authorization.
- The MAA dental program will cover only one set of dentures in a ten-year period.
- Dentures placed immediately must be of structure and quality to be considered the permanent set. *Transitional or treatment dentures are not covered.*
- No additional reimbursement is allowed for *denture insertions*

05110	Complete upper	No	\$365.72	\$346.77
05120	Complete lower	No	\$365.72	\$346.77
0515D*	Dentures/partials where patient died, moved, etc. Laboratory and professional fees may be paid for full or partial dentures if the patient: <ul style="list-style-type: none"> • Does not participate in completing the dentures; • Moves from the state; • Cannot be located; or • Dies. Invoice must be attached listing lab and professional fees.	Yes	By Report	By Report

Partial Dentures (including 6 months post-delivery care)

- One partial per arch will be covered.
- Cast Base Partial Dentures (procedure codes 05213 and 05214) will be covered only when replacing 3 or more teeth per arch, excluding tooth numbers 1, 16, 17, and 32.
- Resin Base Partial Dentures (procedure codes 05211 and 05212) will be covered when fewer than 3 teeth are being replaced, excluding tooth numbers 1, 16, 17, and 32.
- MAA will pay for partials covered by MAA once in 5 years.
- Laboratory and professional fees may be paid under procedure code 0515D* for a partial.

05211	Maxillary partial denture – resin base Includes any conventional clasps, rests and teeth.	No	\$155.56	\$147.11
05212	Mandibular partial denture – resin base Includes any conventional clasps, rests and teeth.	No	\$155.56	\$147.11
05213	Maxillary partial denture – cast metal framework with resin denture bases. Includes any conventional clasps, rests and teeth.	No	\$328.25	\$334.82
05214	Mandibular partial denture – cast metal framework with resin denture bases. Includes any conventional clasps, rests and teeth.	No	\$328.25	\$334.82

* Not an ADA CDT Code

ADA Procedure Code	Description	Prior Auth?	Maximum Allowable	
			0-18 yrs	19 yrs & up

Adjustments to Removable Prostheses

<ul style="list-style-type: none"> No allowance for adjustments for 6 months following placement. Adjustments done during this period are included in denture/partial allowance. 				
05410	Adjust complete denture – maxillary	No	\$16.48	\$15.76
05411	Adjust complete denture – mandibular	No	\$16.48	\$15.76
05421	Adjust partial denture – maxillary	No	\$16.48	\$15.76
05422	Adjust partial denture – mandibular	No	\$16.48	\$15.76

Repairs to Complete Dentures

05510	Repair broken complete denture base Arch designation required.	No	\$37.09	\$34.68
05520	Replace missing or broken teeth – complete denture Use for initial teeth. Tooth designation required.	No	\$32.97	\$31.53
0552D*	Each additional tooth Tooth designation required.	No	\$9.27	\$8.40

Repairs to Partial Dentures

05610	Repair resin denture base. Arch designation required.	No	\$34.00	\$32.58
05630	Repair or replace broken clasp Arch designation required.	No	\$51.51	\$48.34
05640	Replace broken teeth, per tooth. Use for initial tooth. Tooth designation required.	No	\$32.97	\$31.53
0565D*	Each additional tooth Tooth designation required.	No	\$9.27	\$8.40
05650	Add tooth to existing partial denture. Does not involve clasp or abutment tooth. Tooth designation required.	No	\$39.15	\$36.78
05660	Add clasp to existing partial denture. Involves clasp or abutment tooth. Tooth designation required. Existing partials only.	No	\$87.57	\$83.02

* Not an ADA CDT Code

ADA Procedure Code	Description	Prior Auth?	Maximum Allowable	
			0-18 yrs	19 yrs & up

Denture Rebase Procedures

05710	Rebase complete upper Requires justification (e.g., lost vertical dimension, incorrect bite). Original dentures must be at least 3 years old. Rebase will be allowed once in a 5-year period.	No	\$190.59	\$180.74
05711	Rebase complete lower Requires justification (e.g., lost vertical dimension, incorrect bite). Original dentures must be at least 3 years old. Rebase will be allowed once in a 5-year period.	No	\$190.59	\$180.74
05720	Rebase upper partial denture Requires justification (e.g., lost vertical dimension, incorrect bite). Original dentures must be at least 3 years old. Rebase will be allowed once in a 5-year period.	No	\$123.62	\$116.64
05721	Rebase lower partial denture Requires justification (e.g., lost vertical dimension, incorrect bite). Original dentures must be at least 3 years old. Rebase will be allowed once in a 5-year period.	No	\$123.62	\$116.64

Denture Reline Procedures

<ul style="list-style-type: none"> • Relines will not be reimbursed if done within 6 months after seating date. Cost is included in denture allowance. • Reline of partial or full dentures is not allowed more than once in a 5-year period. 				
05750	Reline complete maxillary denture (laboratory)	No	\$111.26	\$105.08
05751	Reline complete mandibular denture (laboratory)	No	\$111.26	\$105.08
05760	Reline maxillary partial denture (laboratory)	No	\$101.99	\$96.68
05761	Reline mandibular partial denture (laboratory)	No	\$101.99	\$96.68

* Not an ADA CDT Code

ADA Procedure Code	Description	Prior Auth?	Maximum Allowable	
			0-18 yrs	19 yrs & up

Other Removable Prosthetic Services

05850	Tissue conditioning maxillary, per denture unit Included in allowance for dentures if service is provided within first six months of placement of denture. Arch designation required.	No	\$19.57	\$18.91
05851	Tissue conditioning, mandibular Included in allowance for dentures if service is provided within first 6 months of placement of denture. Arch designation required.	No	\$19.57	\$18.91
05932	Obturator prosthesis, definitive	No	\$544.98	\$515.95
05952	Speech aid prosthesis, pediatric	No	\$762.35	\$721.91

* Not an ADA CDT Code

ADA Procedure Code	Description	Prior Auth?	Maximum Allowable	
			0-18 yrs	19 yrs & up

Adjunctive General Services

Unclassified Treatment

09110	Open and drain (palliative treatment), apical abscess. Open and drain is included in fee for root canal when performed during same sitting. Tooth or quadrant designation required.	No	\$45.00	\$45.00
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Anesthesia

09220	General Anesthesia Requires justification (e.g., mentally impaired, difficult surgery, fractures for children). General anesthesia administered by the operating dentist may be reported by using this code and showing actual anesthetic administration time. Providers certified for Conscious Sedation must submit proof of certification to the Provider Enrollment Unit to be allowed to bill for these services (see Important Contacts section). See pages L1/L2 for coverage policies.	No	By Report	By Report
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Drugs

09610	Therapeutic drug injection		\$11.11	\$10.51
09630	Other drugs Bill pharmaceuticals using this procedure code. Payable only in conjunction with general anesthesia (09220).		By Report	By Report
0075D*	Unspecified (By report – to be described by statement of attending dentist.) Indicate procedure to be performed and submit report.	Yes	By Report	By Report

* Not an ADA CDT Code

ADA Procedure Code	Description	Prior Auth?	Maximum Allowable	
			0-18 yrs	19 yrs & up

Other Surgical Procedures

Multiple surgical procedures are paid in decreasing percentages:

Highest value procedure	100 % of MAA's maximum allowance
Second or more procedures	50 % of MAA's maximum allowance

CPT™ Procedure Code	Description	Follow-up Days	Assistant Surgeon Allowed?	Maximum Allowable (All Ages)
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Integumentary System

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Skin, Subcutaneous

NFS

FS

Excision – Debridement

11044	See your CPT manual for description.	10	No	142.27	127.51
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Biopsy

11100	See your CPT manual for description.	Zero	No	42.06	25.95
11101	See your CPT manual for description.	Zero	No	20.80	13.42
11440	See your CPT manual for description.	10	No	63.53	41.38
11441	See your CPT manual for description.	10	No	77.40	55.25
11442	See your CPT manual for description.	10	No	87.69	64.43
11443	See your CPT manual for description.	10	No	111.40	84.33
11444	See your CPT manual for description.	10	No	138.47	110.73
11446	See your CPT manual for description.	10	No	172.47	143.62
11640	See your CPT manual for description.	10	No	84.78	58.61
11641	See your CPT manual for description.	10	No	114.76	87.02
11642	See your CPT manual for description.	10	No	131.09	104.02
11643	See your CPT manual for description.	10	No	153.68	123.71
11644	See your CPT manual for description.	10	No	191.26	157.04
11646	See your CPT manual for description.	10	No	247.86	229.96
12001	See your CPT manual for description.	10	No	72.93	56.37
12002	See your CPT manual for description.	10	No	80.08	63.31
12004	See your CPT manual for description.	10	No	95.52	77.85

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Dental Program

CPT™ Procedure Code	Description	Follow-up Days	Assistant Surgeon Allowed?	Maximum Allowable (All Ages)	
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12005	See your CPT manual for description.	10	No	118.56	99.55
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NFS FS

12011	See your CPT manual for description.	10	No	77.62	59.95
12013	See your CPT manual for description.	10	No	87.91	69.57
12015	See your CPT manual for description.	10	No	131.54	109.39
12016	See your CPT manual for description.	10	No	159.50	138.25

Repair – Intermediate

12031	See your CPT manual for description.	10	No	89.03	67.56
12032	See your CPT manual for description.	10	No	101.34	77.62
12034	See your CPT manual for description.	10	No	120.57	102.68
12035	See your CPT manual for description.	10	No	138.69	123.04
12051	See your CPT manual for description.	10	No	102.68	78.97
12052	See your CPT manual for description.	10	No	115.21	88.14
12053	See your CPT manual for description.	10	No	128.63	110.96
12054	See your CPT manual for description.	10	No	151.00	131.09
12055	See your CPT manual for description.	10	No	190.59	168.22

Repair – Complex

13131	See your CPT manual for description.	10	No	153.01	124.60
13132	See your CPT manual for description.	10	No	243.83	200.66
13133	See your CPT manual for description.	90	No	77.18	73.37
13150	See your CPT manual for description.	10	No	164.87	138.92
13151	See your CPT manual for description.	10	No	188.58	151.00
13152	See your CPT manual for description.	10	No	272.91	221.24
13153	See your CPT manual for description.	Zero	No	84.78	79.86

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CPT™ Procedure Code	Description	Follow-up Days	Assistant Surgeon Allowed?	Maximum Allowable (All Ages)	
				NFS	FS
13160	See your CPT manual for description.	90	No	361.05	361.05

Adjacent Tissue Transfer or Rearrangement

14040	See your CPT manual for description.	90	No	353.22	287.90
20220	See your CPT manual for description.	Zero	No	85.45	66.66
20520	See your CPT manual for description.	10	No	103.13	80.31
21030	See your CPT manual for description.	90	No	248.98	219.67
21031	See your CPT manual for description.	90	No	156.37	120.80
21032	See your CPT manual for description.	90	No	158.60	123.48
21034	See your CPT manual for description.	90	Yes	570.21	570.21
21040	See your CPT manual for description.	90	No	114.76	84.78
21041	See your CPT manual for description.	90	No	286.56	238.69
21044	See your CPT manual for description.	90	Yes	480.28	480.28
21045	See your CPT manual for description.	90	Yes	659.24	659.24

Introduction or Removal

21076	See your CPT manual for description.	10	No	600.41	483.42
21077	See your CPT manual for description.	90	No	1,511.09	1,216.93

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CPT™ Procedure Code	Description	Follow-up Days	Assistant Surgeon Allowed?	Maximum Allowable (All Ages)
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Repair, Revision or Reconstruction

NFS

FS

21141	See your CPT manual for description.	90	Yes	721.43	721.43
21142	See your CPT manual for description.	90	Yes	764.61	764.61
21143	See your CPT manual for description.	90	Yes	759.24	759.24

Fracture and/or Dislocation

21336	See your CPT manual for description.	90	No	240.03	240.03
21337	See your CPT manual for description.	90	No	151.22	129.30
21344	See your CPT manual for description.	90	Yes	724.56	724.56
21346	See your CPT manual for description.	90	No	460.60	460.60
21347	See your CPT manual for description.	90	Yes	525.47	525.47
21348	See your CPT manual for description.	90	Yes	644.03	644.03
21355	See your CPT manual for description.	10	No	147.87	130.64
21356	See your CPT manual for description.	10	No	187.01	187.01
21360	See your CPT manual for description.	90	Yes	296.85	296.85

NFS

FS

21365	See your CPT manual for description.	90	Yes	621.21	621.21
21366	See your CPT manual for description.	90	Yes	694.36	694.36
21385	See your CPT manual for description.	90	Yes	407.81	407.81
21406	See your CPT manual for description.	90	Yes	294.17	294.17
21407	See your CPT manual for description.	90	Yes	369.78	369.78
21408	See your CPT manual for description.	90	Yes	503.77	503.77
21421	See your CPT manual for description.	90	No	266.43	248.08
21422	See your CPT manual for description.	90	Yes	382.75	382.75
21423	See your CPT manual for description.	90	Yes	446.95	446.95
21436	See your CPT manual for description.	90	Yes	1,025.44	1,025.44

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Dental Program

CPT™ Procedure Code	Description	Follow-up Days	Assistant Surgeon Allowed?	Maximum Allowable (All Ages)	
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21445	See your CPT manual for description.	90	Yes	268.89	250.10
21453	See your CPT manual for description.	90	No	284.10	265.53

NFS FS

21462	See your CPT manual for description.	90	Yes	459.93	443.82
21470	See your CPT manual for description.	90	Yes	669.09	669.09
21480	See your CPT manual for description.	Zero	No	41.38	24.61

Neck (Soft Tissues) and Thorax Excision

21550	See your CPT manual for description.	10	No	82.99	66.44
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CPT™ Procedure Code	Description	Follow-up Days	Assistant Surgeon Allowed?	Maximum Allowable (All Ages)
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Respiratory System

Nose – Repair

NFS

FS

30580	See your CPT manual for description. <i>(This procedure is not reimbursed if performed within 7 days of surgery to allow for healing.)</i>	90	No	284.77	246.52
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CPT™ Procedure Code	Description	Follow-up Days	Assistant Surgeon Allowed?	Maximum Allowable (All Ages)	
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Digestive System

Vestibule of Mouth

NFS FS

Incision

40800	See your CPT manual for description.	10	No	55.25	37.36
40801	See your CPT manual for description.	10	No	104.69	88.59
40806	See your CPT manual for description.	Zero	No	19.24	16.78

Excision, Destruction

40808	See your CPT manual for description.	10	No	51.23	46.31
40819	See your CPT manual for description.	90	No	106.93	97.76

Repair

40831	See your CPT manual for description.	10	No	106.93	106.93
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CPT™ Procedure Code	Description	Follow-up Days	Assistant Surgeon Allowed?	Maximum Allowable (All Ages)	
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Tongue and Floor of Mouth Incision

NFS FS

41000	See your CPT manual for description.	10	No	61.74	49.66
41005	See your CPT manual for description.	10	No	57.49	51.67
41006	See your CPT manual for description.	90	No	128.18	121.69
41007	See your CPT manual for description.	90	No	142.94	138.69
41008	See your CPT manual for description.	90	No	126.39	118.56
41009	See your CPT manual for description.	90	No	160.62	155.70
41010	See your CPT manual for description.	10	No	59.50	59.50
41015	See your CPT manual for description.	90	No	144.73	136.46
41016	See your CPT manual for description.	90	No	179.63	174.49
41017	See your CPT manual for description.	90	No	154.13	146.97
41018	See your CPT manual for description.	90	No	213.19	205.58

Excision

41108	See your CPT manual for description.	10	No	56.60	50.33
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Dentalalveolar Structures Excision

41825	See your CPT manual for description.	10	No	72.70	61.07
41827	See your CPT manual for description.	90	No	162.18	139.14
41830	See your CPT manual for description.	10	No	155.70	152.12

Other Procedures

41874	See your CPT manual for description.	90	No	143.39	138.25
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CPT™ Procedure Code	Description	Follow-up Days	Assistant Surgeon Allowed?	Maximum Allowable (All Ages)
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Palate, Uvula

NFS FS

Excision

42106	See your CPT manual for description.	10	No	102.90	89.48
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Repair

42180	See your CPT manual for description.	10	No	111.85	107.15
42182	See your CPT manual for description.	10	No	163.08	163.08
42200	See your CPT manual for description.	90	Yes	474.02	474.02
42205	See your CPT manual for description.	90	Yes	433.53	433.53
42210	See your CPT manual for description.	90	Yes	589.00	589.00
42220	See your CPT manual for description.	90	Yes	294.39	294.39
42225	See your CPT manual for description.	90	Yes	403.33	403.33
42227	See your CPT manual for description.	90	Yes	382.08	382.08
42235	See your CPT manual for description.	90	Yes	316.54	316.54
42280	See your CPT manual for description.	10	No	74.72	68.45
42281	See your CPT manual for description.	10	No	80.31	74.27

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